

Special managed care insert • Medicare analysis • Physician profiles • Bioethics

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Up Close:
Michigan Health Plans
MSMS study will benefit both
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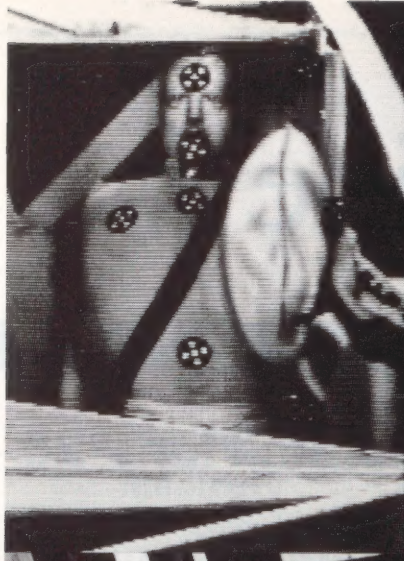
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MichiganMedicine

COVER STORY



Michigan Health Plans 28

The Michigan State Medical Society is in the process of conducting a comprehensive evaluation of Michigan Health Plans. Scheduled for release in March, the evaluation will offer physicians the information they need to make informed decisions about their health plan options. The evaluation also will help patients make more informed health insurance choices. This month's cover story provides a concise outline of the goals and objectives of the evaluation.

Cover photo by: Roger Hill

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Managed Care: Helping physicians navigate the new environment

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Welcome to Your New Michigan Medicine!

By John H. McLaughlin, MD, Chair

As you can see, Michigan Medicine, the Michigan State Medical Society's flagship publication for 94 years, has a new look. As a result of thoughtful research, exciting changes have been made in both the content and design of Michigan Medicine. It is with great pride that I tell you how these changes came to be.

want when they want it. With the rapid advancement of these information vehicles, it is crucial that Michigan Medicine continue to be an updated and lively source of information in the manner we physicians want and need.

At the direction of MSMS, Rossman Martin & Associates, a Lansing-based public relations consulting firm, conducted a series of focus groups. To supplement these, Rossman Martin & Associates and MSMS also prepared and distributed survey questionnaires via mail to approximately 150 randomly selected MSMS members.

In general, the findings from both the focus groups and reader surveys were positive. Some of the key findings include:

- That the vast majority of MSMS members read each or most issues of Michigan Medicine.
- That the majority of respondents at least skim the magazine for articles of interest.
- That MSMS members largely like the design of the magazine.
- That MSMS members largely

like the content of the magazine.

While overall opinions were positive, members indicated that improvements could be made to make the publication more useful. Suggestions included:

- Featuring more general interest, non-medical articles.
- Featuring shorter, more reader-friendly articles.

Since the focus groups and readership survey



MSMS Committee on Publications Chair John H. McLaughlin, MD, (left) discusses format changes with Committee member John M. MacKeigan, MD.

In the life of every publication comes the time to evaluate its effectiveness as a communications tool. Last spring, MSMS staff felt the time was right to evaluate the effectiveness of Michigan Medicine because 1) no formal assessment of Michigan Medicine had been conducted since 1990, and 2) advances in electronic communication (i.e., Internet, E-mail, fax) are providing users with quick, easy access to information they

were conducted, Michigan Medicine staff, along with members of the MSMS Communications Department, and Roger Martin, of Rossman Martin & Associates, held a brainstorming session at MSMS headquarters to discuss the editorial direction of Michigan Medicine in 1996 and beyond. We decided that Michigan Medicine content should be revised/improved as should be the magazine's design. We also decided that the "new" Michigan Medicine should be launched in January of 1996.

The overall themes/goals of redesigning Michigan Medicine include:

- To make the magazine easy to use and more reader-friendly.

- To make the magazine more interactive, providing readers with every opportunity to respond to news in the magazine, to voice their opinions, etc.

- To provide more articles, shorter in length.

- To establish a balance between "hard" and "soft" news/features.

- To help our members share/remember/celebrate the joy of medicine.

A key objective in redesigning Michigan Medicine is to make the magazine more visually appealing. MSMS senior staff, editors and a professional designer have planned several steps to accomplish this, including:

1. Creating a consistent design flow throughout the magazine. As you will see, every page in the magazine blends together graphically. This was accomplished by utilizing the same (more attractive) typefaces and other graphic techniques. At the same time, steps have been taken to distinguish departments from standing features and standing features from the cover story.

2. Utilizing more art, photos, illustrations and color. Certainly making any publication more visually stimulating requires using art, photos, illustrations and color. The new Michigan Medicine will utilize all of these design tools.

3. Featuring shorter, more reader-friendly articles. Strictly from the design perspective, steps



have been taken to make articles look more inviting. This includes using call outs, article summaries and sidebars, and tightly written copy.

Some of the new features we will be seeing include Point/Counterpoint, Life's Pleasures, Physician Profiles, and Backtalk.

The Committee on Publications is excited about the changes in store. Take some time to review your new magazine and let us know what you think. We want to hear your comments, suggestions and, yes, even your criticisms. You may mail your comments to: Michigan Medicine, PO Box 950, East Lansing, MI 48826-0950, or phone (517) 336-5749, or E-Mail bmcnerney@msms.org

Members of the Committee are: Thomas R. Berglund, MD; Jeffrey M. Jones, MD; Dorothy M. Kahkonen, MD; and John M. MacKeigan, MD. ■

Doctor McLaughlin (center) reviews mock-ups of the new Michigan Medicine with Committee members Jeffrey M. Jones, MD, (left) and Dorothy M. Kahkonen, MD.

Question:

What is the greatest myth or misconception about physicians?

“One is that we’re driven by money — or that we choose our specialty by the amount of money we’ll make. Every physician I know has chosen their specialty by what’s most fascinating to them, and what they thought would make the biggest difference in people’s lives. That’s what got most of us into medicine, and what continues to drive us on a daily basis.”

Brian R. McCardel, MD, age 37
Orthopedic Surgeon, East Lansing

“Number one, that they don’t care — when in fact, most physicians care deeply. Number two, that all physicians are rich, when in fact a fair number of physicians make less per hour than some skilled tradesmen.”

Louis R. Zako, MD, age 64
Family Physician, Petoskey

“We’re not Gods. We’re just human beings doing our jobs.”

Peter Aliferis, MD, age 65
Pathologist, Alpena

“Each specialty attracts its own type of physicians with their own specific traits and personality types. The kind of personality we are impacts the public’s perception of us. The other important aspect of the public’s perception is their own expectations, inner wishes and past experience. It is the interaction of the two that shapes the public’s perception. There is not one greatest myth, there are many myths and many misconceptions.”

Evangeline J. Spindler, MD
Psychoanalyst, Ann Arbor

“I think everybody thinks we’re arrogant. It’s almost as if we have to prove that we’re nice people. We’re judged arrogant because we

have MD next to our name.”

Paul O. Farr, MD, age 49,
Gastroenterologist, Grand Rapids

“Most people expect doctors to know the intricacies in all aspects of medicine, and to be able to manage any illness from a brain tumor to a broken ankle. As a specialist, I feel the evolution of medical knowledge has allowed us in-depth understanding of many conditions that would not be possible if there were not subspecializations in medical fields.”

Wendy Larson, MD, age 30
Neurologist, Ann Arbor

“The greatest misconception is that they are so well off that they can tell patients with nothing wrong with them the truth.”

James McGillicuddy, MD, age 54
General Surgery, Lansing

“The biggest myth about doctors is that we forget what our patients tell us. We don’t. We do remember what they tell us. Sometimes we appear so composed that we don’t always show a reaction to what they say.”

Cecil R. Jonas, MD, age 58
Obstetrics and Gynecology, Southfield

BackTalk is a nonscientific sampling of Michigan physicians’ opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490.

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The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editor nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS, with the exception of a few.

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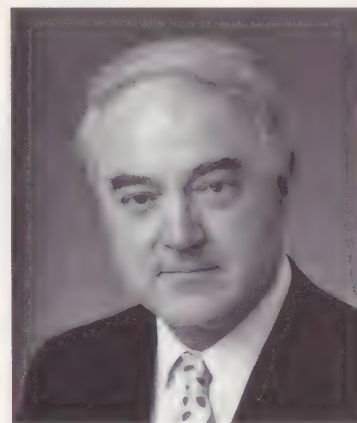
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New physician disciplinary issues

By Richard D. Weber, MSMS Legal Counsel



Q: Is it true that a physician must report another physician who is suspected of violating the law?

A: 1994 amendments to the Public Health Code require all health professionals to report other health professionals to the state licensing authorities, but only if the health professional has "knowledge" that the other health professional has committed a violation under Section 16221 or Article 7 or a rule promulgated under Article 7. Therefore, the technical answer to your question is no, if it is based merely upon suspicion. If it is based upon knowledge of a violation, however, reporting is required. The specific section of the Public Health Code sets forth the grounds for discipline of all health professionals and Article 7 relates to controlled substances. The report must specify the conduct and the name of the other health professional. The information is confidential unless disciplinary proceedings are initiated and the reporting professional is required to testify. This mandatory reporting requirement does not apply to a health professional who obtains knowledge of a violation while providing professional services to the other health professional as a patient, or while serving on a peer review committee of a professional association or health facility.

Q: Does this reporting requirement extend to other health

professionals who are impaired?

A: A health professional who has "reasonable cause to believe" that another health professional is impaired is required to report to the Health Professional Recovery Committee, rather than the state licensing authorities. This requirement is not based upon "knowledge," but a less stringent requirement of "reasonable cause to believe." Impairment is defined as "the inability or immediately impending inability of a health professional to practice his or her health profession in a manner that conforms to the minimum standards of acceptable and prevailing practice for that health profession due to the health professional's substance abuse, chemical dependency, or mental illness, or the health professional's use of drugs or alcohol that does not constitute substance abuse or chemical dependency." The same mandatory reporting requirement exceptions relative to the physician-patient privilege and peer review apply to this reporting requirement.

Q: If a physician fails to report another physician under circumstances in which a report should have been made, and a patient is injured, can the nonreporting physician be legally liable?

A: Failure to report does not subject a health professional to a civil cause of

action for damages. Failure to report may, however, subject the nonreporting health professional to possible disciplinary action under the Public Health Code.

Q: Is it true that a physician's license is automatically suspended for DUIL conviction?

A: MSMS-sponsored legislation has recently been enacted. This new legislation amends the law so that summary suspension for a misdemeanor involving alcohol is not mandatory, but discretionary, and only if there is a determination that the public health, safety and welfare requires such emergency action. The 1994 amendments to the Public Health Code mandated a summary suspension (without a hearing) of licensure of a health care professional who is convicted of a misdemeanor involving the illegal delivery possession, or use of alcohol or a controlled substance. Licensure suspension has far-reaching ramifications and to automatically suspend a license for a misdemeanor that may have nothing to do with the practice of the health profession was unfair and singled out the health care professions as the only group subject to such summary suspension. ■

Mr. Weber is a senior partner with Kerr, Russell & Weber, Detroit.

Send your legal questions to Michigan Medicine, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490, or send them by E-mail to bmcnerney@msms.org.



Helping Physicians Navigate the Managed Care Environment

*By William E. Muligan
MSMS Executive Director*

Managed care is the health care controversy of the '90s. Physicians are divided over whether to embrace the concept or to delay its arrival as long as possible. While the position of the Michigan State Medical Society is not to advocate one particular health care delivery system over others, one message is clear: managed care is evolving here in Michigan -- and quickly -- and it is physicians, not third party payers or employers -- who should be taking the lead to shape its future direction.

Let's take a moment to review some of the findings of our **1994 Survey on Practice Characteristics**, which is based on responses from active members:

A larger percentage of physicians have managed care contracts than in 1992, a reflection of the continued penetration of managed care plans in the Michigan market. Sixty-nine percent of physicians had a contract with an HMO, as opposed to 64 percent in 1992. Seventy-four percent have a contract with a PPO, up from 65 percent in 1992.

The majority do not plan to change their managed care affiliations in the coming year, but of those who do plan changes, adding new plans is the most common response.

Among those who do not yet have any managed care contracts, nearly half say they plan on signing a contract in the next year.

To help physicians develop the skills they need to manage the managed care explosion and, more importantly, to successfully compete in this new environment, MSMS has developed a series of initiatives aimed at education, services and advocacy.

Details of these initiatives are included in this special report. I encourage you to review them and take the necessary steps to ensure your success now and in the future.



Is There a Physician Organization in Your Future?

By Fred E. Patterson, MD

"The sophistication required to negotiate contracts, manage risk, measure outcomes and prove value to the payers will be beyond the capability of the sole practitioner."

"A doctor's traditional role as an advocate for the patient can best be preserved by a physician-owned and directed organization."

The only way you could answer "no" to this question is if you were to leave the practice of medicine. This may seem like an extreme statement, but we are in an era where rapid, profound changes are occurring that are irreversible. The change that is occurring may be lamentable and not to our liking, but this is a change that cannot be stopped. It is important that we be the leaders in this process of change.

These changes have been developing for several years. They are driven by the relentless increase in the cost of health care. The rate of increase in health care expenditures is no longer sustainable. We must be the leaders of the reorganization of health care so that we provide affordable, high value services for our community.

In this new era there are assumptions about health care that are becoming basic:

1. Health care is a local phenomenon.
2. Physicians, hospitals and others who provide services in health care must demonstrate how they are performing, and adding value.
3. The payers for health care are the dominant driving economic force. They are seeking to purchase health care for groups for a fixed amount.
4. Financial risk for medical decisions is being transferred to the clinical decision maker, which in most instances is the physician.

The new economic unit for the practice of medicine is rapidly becoming a group of physicians. The sophistication

required to negotiate contracts, manage risk, measure outcomes and prove value to the payers will be beyond the capability of the sole practitioner. By necessity, nearly all physicians will be grouped so that a response to the economic market forces can be made. Ideally, physicians will form groups under physician leadership to develop the capabilities to meet the needs of the payers. However, some physicians may prefer to be employees of lay-organizations who are willing to accept the challenge.

It is the position of the Society's Physician Organizations Committee that physicians can build an organization that can respond to the marketplace in a better way than a lay-directed organization. A doctor's traditional role as an advocate for the patient can best be preserved by a physician-owned and directed organization. Doctors, of course, cannot do it alone. We need to develop the skills of a team leader along with the ability to partner with many others to meet the demands of managed care. We will need the assistance of business managers, hospitals and experts in many other fields such as insurance and information systems.

The future belongs to the organization that can be both clinically and financially effective and efficient in both the short and long run. Physicians are ideally positioned to successfully form these organizations.

Doctor Patterson is chair of the MSMS Physician Organizations Committee.

PO case study details keys to PO success

In a continuing effort to keep MSMS members and staff informed about the changing health care environment, MSMS representatives recently conducted a series of site visits to physician organizations across the country. Findings of these site visits are detailed in a PO case study available from MSMS. To obtain a copy, contact Shannon Stockwell at MSMS at (517) 336-7594.

Integration of Physician Practices leads to better organization and collective clout

By James J. Aluia

In response to health care's movement toward managed care, many physician practices have already undergone some form of consolidation. Currently, one of the fastest growing segments of health care is the merger or consolidation of group practices. By joining forces, physicians are better able to compete in a market place that is continually changing. In addition, consolidations/mergers put physicians on a progressive pathway that allows them to take advantage of advances in medical technology and methodologies to support an industry that is changing from an inpatient-based to an outpatient-based practice. Physicians who have already integrated or have begun to consolidate their practices with others have learned that they simultaneously require considerable modernization of the management, operational, financial and marketing aspects of their practices.

The integration of physician practices has developed quickly throughout the United States. It has developed as IPAs, physician organizations, clinics without walls, limited liability corporations or fully integrated facilities of physicians by specialty and/or multi-specialty groups. A new model which is helping physicians further this organization process is the management service organization (MSO). This vehicle can help provide contracting and negotiating, legal, accounting, MIS, centralized billing, facility planning/management services and group purchas-

ing for items such as health insurance, malpractice insurance or supplies.

What consolidation/integration or other corporate models bring to the physician is better organization and more collective clout when it comes to negotiating managed care contracts.

Most practice consolidations may take 90 days or longer to consummate. The most critical choice is that of who your potential partner will be. Most potential partners must be a known quality, someone that you know from your experience at the hospital or involvement in other portions of the health care community.

There are some guidelines to follow in beginning a consolidation effort:

- Define what you want the group to be when the consolidation is completed.
- Determine what the compatibility of all of the providers who will practice in the proposed new organization.
- Develop some business plan to gauge the efforts of the consolidation progress.
- Try to identify what will be different from the new group and the availability of that group to attract purchasers of your services.
- Trust is the very foundation of any relationship. The physicians must all trust each other.

Mr. Aluia is chief of practice development and PO development for MSMS

There are many reasons which are driving this consolidation movement in the industry. Among these are:

- The growing complexities of administration in medicine
- The security of being involved in larger groups
- A decrease in reimbursement rate
- Increases in practice overhead

The following are some of the advantages of consolidation:

- As competition becomes stronger, larger multi-specialty groups need to take care of more patients. Consolidated entities are capable of sharing expenses, resources and avoiding duplication in overhead expenses
- Consolidated physician groups can offer a larger range of services and have a much greater potential to expand those services.

The movement of outpatient services from a hospital setting to the physician's office may require expensive equipment. A larger group of physicians will have a much easier time in capitalizing the need for additional expensive equipment.

- Larger groups of physicians can offer purchasers of health care options that neither hospitals nor other organizations can provide.
- Many physicians like the security offered by larger groups.
- Groups can develop more sophisticated fringe benefit and retirement packages.



Changing Physicians' Needs Spur Development of MSMS Programs and Services

MSMS and its subsidiaries have been quick to anticipate and respond to the trends toward group practices, mergers, and managed care. Following is a brief rundown of the many initiatives MSMS has taken to help physicians succeed in a managed care environment.

Physician Organization and Management Services (POMS)

In 1993, MSMS established Physician Organization and Management Services (POMS), the only consulting service in Michigan, developed by physicians for the advancement of physicians' interests. MSMS established POMS not only to educate its members about managed care and POs, but more importantly, to actually provide the services physicians need to organize and operate POs. MSMS believes that health care, like politics, is basically a local or regional activity. Thus, its strategy is to help physicians develop physician-driven, local networks. POMS has helped establish eight POs that include nearly 1,000 Michigan physicians and communicates regularly with nearly 90 physician groups across the State.

Consulting Services

Through POMS, MSMS provides consulting services concerning PO formation and operation through a network of "physician oriented" expert consultants. By providing such services as market research, strategic planning and business plan development, legal services, interim CEO services, and merger planning and facilitation, POMS offers

physicians a complete package of services necessary to form successful organizations.

POMS also has served as an executive search firm for two physician groups. This has involved interviewing and screening potential CEO candidates and recommending qualified candidates to the PO's Board of Directors. In addition, POMS has provided interim CEO services to three POs who decided not to hire a full-time CEO immediately, but still needed staff to run the day-to-day affairs of the organization.

PO/PHO Case Studies

A major educational activity undertaken by POMS has been participation in the PHO and PO case study projects. These projects have been sponsored by the AMA, MSMS, the Indiana State Medical Association and the Illinois State Medical Society. Extensive interviews were held with the key physicians, administrators and administrative staff of these organizations to determine the key factors influencing the success of these groups.

Discussions are underway for a third case study project, which will focus on Management Services Organizations

(MSOs) established by physician organizations, hospitals and state medical societies. At this time, the AMA, Indiana State Medical Association, Massachusetts Medical Society, and the American Academy of Otolaryngology have agreed to participate along with MSMS in this next phase.

Physician Review Organization of Michigan (PROM)

MSMS is currently providing quality assurance and utilization review services to physicians and insurance companies through one of its subsidiaries, Physicians Review Organization of Michigan.

Developed and governed by physicians, PROM is an independent peer review organization that provides utilization review and quality assurance services such as concurrent review, retrospective review, bylaws/protocols, practice guidelines development, and regulatory compliance. Utilizing 200 physicians of all specialties for this peer review service, PROM provides an average of 3,500-4,000 case reviews annually.

PROM also conducts quality assurance monitoring for the Michigan Department of Social Services, providing administrative audits and peer review of

the 4,000 clinical records of Medicaid patients currently enrolled in an HMO.

MSMS also has joint ventured with the Michigan Hospital Association to create the Michigan Professional Credentials Verification Service (MPCVS), a centralized data bank which can be used to provide physician credentialing and recredentialing services to hospitals, POs and a variety of other health care entities.

Group Insurance Trust (GIT)

In addition to the services provided directly by its subsidiaries, MSMS, through its Physician Service Group division, endorses various member programs designed to provide physicians with access to needed services at group rates. By researching various vendors and negotiating on behalf of physicians, MSMS has established a network of vendors providing services such as on-line medical billing, debt collections, accounts receivable management, group purchasing, and insurance products through BCBSM. Further, the MSMS Group Insurance Trust division now offers a competitive stop loss insurance product for physicians entering risk-based contracts.

Michigan Association of Physician Organizations (MAPO)

The purpose of MAPO is to promote physician organization advocacy, ensuring the right of POs to develop, mature and become significant components of integrated health systems.

Membership in MAPO provides a subscription to the Association's journal *Partnerships* for one year. Its continuing focus is to identify successful courses of action for PO members. Also included is a calendar of applicable courses and programs. MAPO members will receive special member rates at various MAPO-sponsored conferences.

For more information, or to become a member of MAPO, please contact Ginger Marenich at (517) 336-7600.

MICHIGAN PHYSICIANS RISE TO CHALLENGE OF EXTRAORDINARY TIMES

Physicians leading organizing efforts in Michigan are ordinary doctors who are rising to the challenge of extraordinary times. *Michigan Medicine* asked several of the physician leaders and others working to organize physician organizations to explain why they have taken the lead and what challenges they have faced. Following are their answers.

"I think the physicians in our community have been good to work with. They understand the environment, and the need to get together in a PO, and then into a PHO. I think it's important for the physicians to be informed on what has happened elsewhere in forming organizations, and how that will apply here. From the hospital viewpoint, we have to be open and honest...we won't take the attitude that we're in control. We have to work toward win/win solutions, so both sides walk away with a gain."

—Burton O. Parks, Administrator
West Shore Hospital (Manistee PHO)
Manistee

"Our group incorporated in May (1995), and now we've got 120 physicians. Logistics are always an issue in the UP. We've avoided being identified as the PO of a specific city. You need to be persistent. Emotions will run high because there is a lot of uncertainty, a lot of doctors wondering if this is really necessary. MSMS helped us develop the business plan, and it's worked out very well."

—Cheryl Vader, CEO
Upper Peninsula Physicians
Network
Marquette

"I'd say it's important to have a clear vision of what [the PO] is all about, and the direction you want to take. Be prepared to spend a lot of time with your board. You should have done a strong market analysis going in. We worked with the MSMS, and they did us a lot of good. My final advice would be to do it now, and don't wait for someone else to do it for you."

—Tom Walters
Executive Director, Oakland
Physicians Network, Pontiac

"Our PHO at Sparrow has been in business for about 16 months. I'd say the first priority is to develop and maintain trust between the physicians and the health system leaders. You need committed leadership, and an open consensual approach from the beginning. The group has to be able to make an educated guess on where the market is going, and make plans that align with your practice goals. I'd say that we weren't aggressive enough on this. Doctors should view this as an enhancement to their practice. This is a great opportunity -- it makes you a better physician."

—Steven TePasste, MD
Sparrow PHO, Lansing

"Some physicians didn't like the formation of a separate PO, but we kept pushing until we were able to convince them that this would be the PO of the PHO. Now all our physicians have to join the PO, and this has caused some problems, but ultimately, we succeeded. My advice for those planning a PO would be, number one, start with good funding. It's very important to have money to put in, and not just dues of \$500 or \$1,000, but \$25,000. You need capital to do it right. Also, you need good legal expertise."

—Bashar Succar, MD
Oakland Physicians Network, Pontiac

Medicare in the Next Millennium:

A more favorable climate for PSOs?

By Ginger Marenich

The need for change in the Medicare system has caused an emotionally charged debate with all parties fighting for what they already believe is an inadequate share of resources. Everyone agrees that fundamental changes need to be made if we want Medicare to continue into the next millennium, yet no one wants to take the brunt of the financial impact.

Often depicted as the greedy recipient of the overburdened taxpayers' dollars, the physician is typically regarded as the participant required to bend in Medicare negotiations. However, physicians have reached a point where their ability to yield exists no more. It is no longer possible to continue to lower reimbursement rates and maintain adequate access to care. Instead, fundamental change is needed in the basic structure and functioning of the system.

Currently under consideration in Congress are measures that could make it easier for physicians to create and control health care plans and health care delivery systems for Medicare patients. As it stands, the Balanced Budget Act of 1995 would favorably modify the current regulatory structure to facilitate the formation of physician sponsored organizations (PSOs).

This legislation could provide physicians with a worthwhile opportunity. Until now it has been very difficult for physician groups to compete with insurance companies and managed care plans. However, the bill has proposed changes that would make it easier for networks to contract directly with Medicare. Fundamental differences between PSOs and insurer-owned plans will be considered in resolving financial solvency, reinsurance, and risk-based capital issues.

The American Medical Association (AMA) and the Michigan State Medical Society (MSMS) have been closely monitoring the proposed legislative changes and are working to inform physicians about the possible effects and opportunities that could result.

What are provider sponsored organizations (PSOs)?

The Balanced Budget Act of 1995 allows for creation of a new option for Medicare beneficiaries called MedicarePlus. This option would allow beneficiaries the opportunity to choose a health plan called a "MedicarePlus Product" offered by a "MedicarePlus Organization" (MPO). A PSO would be a type of MPO that is owned and operated by a health care provider or a group of affiliated health care providers. The affiliated providers would have to be able to provide a substantial part of the Medicare benefit package directly through the provider or affiliated group of providers. In addition, affiliated providers holding a majority interest in the PSO would have to share substantial risk for the services that they deliver.

The types of provider organized entities that could be PSOs include independent practice associations, physician-hospital organizations, large group practices, and networks of hospital-employed physicians.

As can be expected, HMOs and insurance groups are fighting the proposed changes with all their resources. They claim that when physician groups directly contract with employers, they assume risk and basically act as insurers. Therefore, insurance groups believe that this should subject these physician groups to the same restrictions and regulations they face.

At this time, the outcome of this debate is unknown. However, the AMA and MSMS are preparing physicians to help them take advantage of the opportunities that will arise from this legislation.

PO/PHO development:
AMA/MSMS

Should MSMS establish a statewide physician network or MSO?

By Kenneth H. Musson, MD

Earlier this year, the MSMS Board of Directors established the Task Force on Physician Networks to explore what services MSMS can provide to help Michigan physicians succeed in the rapidly changing health care environment. Among the alternatives the Task Force has considered is whether MSMS should create a statewide physician network or HMO, or whether MSMS should establish a management services organization (MSO) to provide products and services for existing physician networks and groups, as well as individual physicians.

Based on the meetings the Task Force has held to date, strong evidence supports the development of an MSMS MSO rather than a statewide physician network or HMO.

Discussions regarding a statewide physician network or HMO included the opinions of employers, antitrust attorneys, representatives of the AMA and state medical societies attempting to form these entities. Employer representatives opposed the idea of a statewide network or HMO, stating they likely would dismiss the concept as an attempt at a monopoly rather than as a serious effort to improve the quality and cost effectiveness of health care delivery. Further, the AMA reported that several state medical society sponsored networks and HMOs are having antitrust problems and difficulties securing managed care contracts because of skepticism by employers.

In order to assess physician needs, the Task Force developed a survey and sent it to nearly 100 physician groups throughout Michigan asking them what products and services they would be interested in

securing from MSMS. In addition, representatives from several Michigan physician groups have spoken to the Task Force concerning what role MSMS should play in helping physicians succeed in a managed care environment. Finally, focus groups of physicians are being held which will assist the Task Force in determining regional and local needs.

The Task Force is now moving forward to evaluate the best possible structure for a society-sponsored MSO. Members of the Task Force and MSMS staff have made arrangements to meet with the Pennsylvania Medical Society (PMS) in order to analyze the MSO PMS has developed. MSMS has retained as a consultant, Stewart Gleischman, MD, who has helped to establish a successful, physician-run MSO in California. Doctor Gleischman currently serves as co-vice chair of the board of the MSO and is a practicing general surgeon. Further, MSMS has taken the lead in organizing a third case study project which will focus on MSOs. Through this study, MSMS, along with the American Medical Association, Indiana State Medical Association, Massachusetts Medical Society and the American Academy of Otolaryngology, will look at MSOs developed by hospitals, for-profit businesses, and POs to determine the key MSO success factors.

The Task Force plans to meet again on February 20 and will submit a report to the MSMS Board of Directors for consideration at its March meeting. If accepted, the report will be brought before the MSMS House of Delegates in April.

Kenneth H. Musson, MD, is President of the Michigan Society of Managed Care (MSMC).

Results from the various reports have pointed to the following as services members would like to see an MSMS MSO provide:

- Credentialing
- Quality assurance/practice guidelines/outcomes/best practices/clinical pathways
- Evaluation or development of a management information system
- Stop loss or other insurance products
- Helping primary care physicians and specialists relate to each other on a team basis
- Developing physician leaders
- Education concerning managed care and physician organizations

Society takes active role in evolution of State's Medicaid system

By Christine Shearer

The Michigan State Medical Society (MSMS) and the Michigan Association of Osteopathic Physicians & Surgeons (MAOP&S) are actively involved in the evolution of Michigan's Medicaid system. The Society's departments of Government Relations and Medical Economics, along with its Physician Organization and Management Services division, have met with Vernon Smith, PhD, director, and staff of the state's Medical Services Administration. Discussions have focused on development of quality based capitation approaches applicable to the current Physician Sponsor Plan.

If Congress passes the House Commerce Committee's *Medicaid Transformation Act of 1995*, it will block grant federal funds to the state and cap annual spending growth under Medicaid. Under federal law, there will be no entitlement for an individual or category of individuals for medical assistance under Congress's new MediGrant plan. This will obviously play a major role in Michigan's Medicaid System.

Doctor Smith has clearly stated that the administration is moving towards capitation of the Plan as the core of the recodified Medicaid system in order to gain more control over costs. He has acknowledged that it will take considerable effort and will require the cooperation and input of the physician community. He also has indicated his willingness to work with MSMS and MAOP&S throughout this extensive process.

A major effort has been to create an area of participation for physician organizations (POs) or physician service networks (PSNs). These efforts are a result of physicians increasingly viewing POs as an optimal vehicle for managed care contracting.

MSMS will continue to work closely with the Family Independence Agency (formerly the Department of Social Services) to create the best possible quality-based capitated system and ensure that Medicaid's primary function is access to health care services for the state's most vulnerable populations.

The author is chief of government relations for MSMS.

If you would like additional information, the following MSMS staff members are available to assist you.

Practice Management Consultants

Jim Aluja (517) 336-7599

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FIFTH ANNUAL JOINT SECTION MEETING SLATED FOR MARCH 1-2, 1996

The fifth annual MSMS Joint Section Meeting will be held March 1-2, 1996, at the Ritz Carlton Dearborn. The meeting will bring together three MSMS membership sections: hospital medical staff, international medical graduates and young physicians.

Now is the time for:

- County medical societies and hospitals to name delegates and representatives to the meeting.
- Physicians to turn issues and concerns into resolutions for all three sections to consider at the meeting.
- All interested physicians to make plans to attend the meeting to speak out on the issues (only delegates and representatives can vote, however).

Keynote speaker for the meeting will be Regina Benjamin, MD, the first designated young physician elected (June 1995) to the American Medical Association Board of Trustees.

A solo family practitioner in Bayou La Batre, Alabama, Doctor Benjamin was named by Time magazine as one of the nation's "50 future leaders age 40 and under."

She will discuss changes underway in organized medicine to better represent the increasing diversity of the US physician population, as well as current national budget trends and their impact on medical care, including graduate medical education.

The meeting will be preceded by a training session the afternoon of March 1 on Internet and MSMSNET skills. An early bird reception is scheduled that evening, followed by business meetings of each section's governing councils. Saturday's sessions will include a general opening and instructions for delegates, addresses by Doctor Benjamin and other key speakers, and concurrent business sessions for each section.

For registration and reservation details, please contact

Betty McNerney—International Medical Graduates Section

F. B. "Tom" Plasman—Hospital Medical Staff Section

Debbie Zannoth—Young Physicians Section

They may be reached at MSMS, PO Box 950, East Lansing, 48826-0950; telephone 517/337-1351; fax 517/337-2490; MSMSNET (bmcnerney@msms.org; tplasman@msms.org or dzannoth@msms.org).

35TH ANNUAL MATERNAL & PERINATAL HEALTH CONFERENCE WILL ADDRESS PRE-CONCEPTION COUNSELING, OTHER ISSUES

The 35th Annual Maternal & Perinatal Health Conference will be held March 28, 1996, at the MSU Management Education Center Center in Troy.

Sponsored by MSMS and the Perinatal Association of Michigan, the conference will begin with a keynote presentation on preconception counseling. Other clinical topics will include use of antenatal steroids, new CDC guidelines for Group B strep, 3D obstetric ultrasound, fetal surgery, active management of labor, and post-delivery management of the depressed term infant. The day-long conference will conclude with a program on shortened hospital stay of mother and baby: problems and prospects.

For more information, call Sarah Cressman, chief of physician education, at (517) 336-5727 or E-Mail her at scressman@msms.org ■



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Muskegon County

AMA President Lonnie R. Bristow, MD, addresses medical society

In a speech at the November 21 meeting of the Muskegon County Medical Society, AMA President Lonnie R. Bristow, MD, urged physicians to contact their federal legislators asking them to support the current budget bill that includes

Medicare reform. "We need to support quality care and do real reforms, not just band-aids," Doctor Bristow said. He also spoke about the AMA's new physician guidelines for recognizing and treating sexual assault, which he termed "a silent, violent epidemic." He urged physicians to help stem the epidemic by studying the guidelines and taking appropriate action when necessary. ■



Local physician leaders pose with Doctor Bristow during the November 21 Muskegon County Medical Society meeting. They were (l to r): John M. MacKeigan, MD, a Grand Rapids colorectal surgeon and member of the MSMS Board of Directors; Thomas E. Stone, MD, a Muskegon urologist and MSMS Board member; Brooker L. Masters, MD, a past MSMS president; Yousif I. Hamati, MD, president, Muskegon County Medical Society; Lonnie R. Bristow, MD; John P. Papp, MD, president-elect, Kent County Medical Society; and James Potter, MD, president-elect, Muskegon County Medical Society.

Wayne County

Society task force developing handbook on abuse

Wayne County Medical Society Task Force on Violence Reduction, chaired by Robert Seski, MD, is working on a handbook that includes guidelines for developing programs designed to identify, treat

and report suspected/actual victims of abuse. This booklet will be distributed to area hospitals on various aspects of domestic violence. The Task Force also will be surveying WCMS membership. The task force will use the survey results to develop an educational program for health care professionals. ■


Genesee County

Society maintains ties with local health coalition

The Genesee County Medical Society continues to be a key member of the Greater Flint Area Health Coalition. The main objective of this coalition is to provide quality health care, increase access and reduce medical costs to those who cannot afford care. Cathy O. Blight, MD, a Flint pathologist and member of the MSMS Board of Directors, and about 50 other physicians in the Flint area provide services to persons needing quality health care. The GCMS Environmental Health Task Force is organizing a meeting on Great Lakes Water Quality to be held in 1996 in Washington DC. Task Force Chair Robert Soderstrom, MD, and other task force members are helping coordinate the seminar with the National Association of Physicians for the Environment. Call Peter A. Levine, GCMS executive director, at 810-238-3781 for more details. ■

Share your news with us

"Across the State" is an excellent vehicle for communicating the activities of your county medical society or specialty society. Send your information to: Tom Seely, MSMS chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950. Phone: (517) 336-5770. Fax: (517) 337-2490. E-mail: tseely@msms.org



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There are tools to help you find information on the Internet

The Internet is increasing in size so rapidly, that aiding people in their quest for information, has become a thriving business.

There are over 100 search engines available for free on the Internet, though many users have one or two favorites that they tend to stick with. A search engine is a

tool used to find information on the Internet. These powerful tools let you quickly search millions of web pages using key word searches. A key word search is a simple search, where you type one or more words which describe the information you are looking for. For instance, by typing "University of Michigan," you should expect to find information relating to the University of Michi-

gan. Additionally, you should expect to find information on Western Michigan University, Michigan State University, or Michigan Tech University.

Below are the top five search engines on the World Wide Web. All can be quickly accessed from the MSMSNET search page <http://www.msms.org/search.html>, or go to the pages directly with the addresses below.

DOWNLOAD CORNER:

One of the many topics covered in depth on the Internet is weather. Almost all of the real-time data collected by the National Weather Service is available on the Internet, but until now there was no easy way to retrieve and display this information on your computer. With the release of WinWeather from the University of Michigan's Weather Underground project, users with a PPP connection to the Internet can now access the current time, date, temperature, humidity, barometric

pressure, wind speed and direction, and condition report from cities all over the world. In addition, extended forecasts for cities in the United States are available by clicking a button. WinWeather's interface is simple and easy to use, and can be set to update the information coming to your computer at intervals as short as one hour. If you are interested in keeping track of Michigan's winter, or seeing what the temperature is in New Delhi, download WinWeather at http://mammatus.sprl.umich.edu/pub/Other_Software/Weather_Software/weather2.zip. This software is currently available in Windows format only.

(WinWeather provides Internet users with real-time custom weather reports.)

FIVE SEARCH ENGINES

Lycos: The first WWW search engine, it has been upgraded recently to improve content and interface.
<http://lycos.cs.cmu.edu/>

WebCrawler: The fastest search engine available.
<http://webcrawler.com/>

Infoseek: The most popular Internet search engine. Fast and comprehensive.
<http://www2.infoseek.com/>

Yahoo: A search engine and a topically arranged index of Internet resources.
<http://www.yahoo.com/>

World Wide Web Worm: The most comprehensive search engine available.
<http://www.cs.colorado.edu/home/mcbryan/WWW.html#search>

"Surfing the Internet" is a monthly Michigan Medicine feature. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Systems, contact Andrew T. Clay at MSMS via E-mail at aclay@msms.org or by phone at (517) 336-7601.

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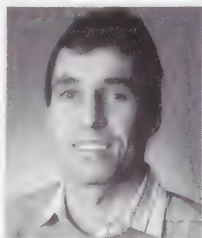
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Outcomes Measurement:

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Ubiquitous, confusing, arcane, and technical are words which often come to mind when thinking about outcomes measurement. What outcomes measurement is and how physicians can best put research into practice was the subject of a two-day conference held late last year in Dearborn. The conference, which attracted about 140 physicians, policymakers and others, was sponsored by MSMS, Michigan Physicians Mutual Liability Co., Blue Cross Blue Shield Foundation, and Blue Cross Blue Shield of Michigan.

tor, Center for Clinical Effectiveness, Henry Ford Health System; Lisa Simpson, MD, MPH, FAAP, acting deputy administrator, Agency for Health Care Policy and Research; Jane Deane Clark, PhD, director, Center for Health Outcomes and Evaluation; Shelly Greenfield, MD, director, Primary Care Outcomes Research Institute, The New England Medical Center; Thomas G. Weatherup, director, Health Care Initiatives, General Motors Corp.; and Dexter Shurney, MD, MBA, senior associate medical director, Blue Cross Blue Shield of Michigan. Moderators for the conference included Peter A. Duhamel, MD, MSMS Board chair; B. David Wilson, MD, MSMS president; John E. Billi, MD; and David R. Rovner, MD.

Following are photo highlights of the conference. An indepth cover story on outcomes measurement will appear in the February issue of the *Michigan Medicine*.

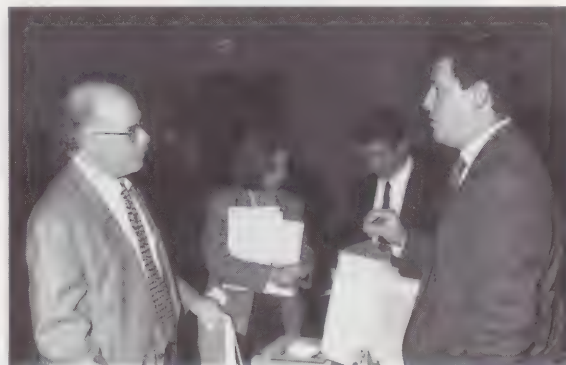


MSMS President B. David Wilson, MD, (right) welcomed John E. Wennberg, MD, a noted expert on outcomes measurement, to the conference.

Keynote speaker John E. Wennberg, MD, MPH, director, Center for Evaluative Clinical Sciences, Dartmouth Medical School, told physicians attending the conference that there are two key issues surrounding outcomes measurement. First, physicians need to learn the clinical outcomes of care, and second, they need to determine patient preferences for treatment.

“The key question is whether a procedure or service is actually wanted by the patient,” he said. Based upon research conducted by the Center for Evaluative Clinical Sciences, Doctor Wennberg said, “A patient’s desire to know (his prognosis and treatment options) doesn’t necessarily correlate with his desire to be treated. Physicians must inform patients of the risks and benefits of treatment and then let the patient decide their course of treatment.”

Also speaking at the conference were: Larry V. Staker, MD, director, Clinical Quality Improvement, Physician Division, Intermountain Health Care; Richard Ward, MD, MBA, direc-



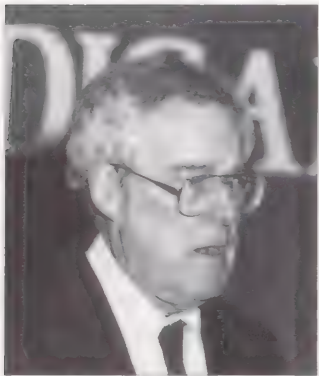
Robert Bree, MD, (left) an Ann Arbor radiologist and member of the MSMS Advisory Committee on Medical Economics, took a moment to chat with Anthony Giammona, of Velocity Healthcare Informatics, Minneapolis, Minn. Velocity Healthcare was one of two vendors invited to exhibit at the conference.



Peter A. Duhamel, MD, chair, MSMS Board of Directors, served as moderator at the two-day conference.



Giovannino A. Perri, MD, (left), and Darlene Born, both of Medical Service Administration, Michigan Department of Social Services, discuss outcomes measurement with keynote speaker John E. Wennberg, MD, during an evening cocktail reception.



John E. Wennberg, MD, MPH, director, Center for Evaluative Clinical Sciences, Dartmouth Medical School, discussed "Variations, Outcomes, Preferences, and Prostate Disease, during his keynote presentation November 16, 1995, in Dearborn.



Richard Ward, MD, MBA, director, Center for Clinical Effectiveness, Henry Ford Health System, discussed "Physician/System Use of Outcomes Data and Practice Guidelines."



Rhoda M. Powsner, MD, JD, MHSA, a physician consultant for Ford Motor Co., described an outcomes study being conducted on benign prostate hypertrophy in an employed population in southeast Michigan and the introduction of shared decision-making.



Douglas R. Woll, MD, (left) medical director of SelectCare, discussed his perspectives on outcomes measurement with Doctor Wennberg.



Sheldon Greenfield, MD, director, Primary Care Outcomes Research Institute, The New England Medical Center, discussed "Severity Adjustment in Outcomes Data."

On being a virtuous physician

Managed care poses many challenges

By John R. Caldwell, MD

"Standing up effectively for patients is one of the attributes of being a virtuous physician."

Syndicated newspaper columnist Joan Beck, of *The Chicago Tribune*, challenges us to put the patient's well being first when working as a physician in a managed care setting. This may not always be so easy considering the constraints which some managed care plans impose on the physician.

Joan Beck writes:

"Much of the savings being wrung out of health care at the expense of physicians and patients is going to pay for a new layer of administration, huge corporate salaries and investor's profits. Treating patients is becoming just a business cost, to be kept as low as possible."

It's simplistic to blame physicians and hospitals for much of the problem of skyrocketing health costs that has spurred the growth of the managed care industry. It's simplistic to argue they must be a big part of the solution to protect patients. But unless they do stand up effectively for patients, who will?

Standing up effectively for patients is one of the attributes of being a virtuous physician.

In the book *Contemporary Issues in Bioethics*, Edmund Pellegrino gives us a good, all embracing definition of virtue. Virtue implies a character trait, an internal disposition, habitually to seek moral perfection, to live one's life in accord with the moral law, and to attain a balance between noble attention and just action.

On almost any view, the virtuous person is someone we can trust to act habitually in a "good" way - courageously, honestly, justly, wisely and temperately. He is someone who will act well even when there is no one to applaud, simply because to act otherwise is a violation of what it is to be a good person.

The physician, before he is anything else, must be a virtuous person.

The patient's good is the end of medicine, that which shapes the particular virtues required for its attainment. That end is central to any notion of the virtues peculiar to medicine.

Patients the world over would like to think that they have a virtuous physician for their medical care.

Qualities of virtuousness

Let us, then, consider some of the qualities that make up a virtuous physician. We will do this using the paradigm of the primary care physician.

Patience

On greeting the patient, he should inspire confidence by his interest and attention to the individual and by his professional bearing. He should allow the patient to relate his complaints and tell his story in his own way - not rushing ahead. In other words, he must have patience - before asking specific, directed questions in his systemic review, past medical and family history.

Comprehensiveness

Continuing with the patient's examination, it must be thorough, giving attention to the major problem. In arriving at a diagnostic impression, he must be comprehensive in his approach to the problem or problems the patient presents and arrive at logical conclusions.

Honesty, with compassion

In ordering diagnostic procedures, laboratory tests and consultations, he must be selective and frugal in accordance with the economics of managed care. In conveying results to the patient, he must be honest and present the truth, as he sees it, but with compassion and empathy.

In treatment, he should be the healer offering encouragement and hope to the patient and bringing his full knowledge and wisdom to bear on his prescription.

Prudence

Some managed care programs are praiseworthy and good, having as a goal offering preventive and appropriate, medically sound, diagnostic and therapeutic care. Some are plus-minus in this respect and some are clearly bad, having as goals the limitation of services so as to cut costs. The physician who finds himself in a health maintenance organization that deliberately seeks to underserve the patient is in an unfortunate position. The physician will have to modify the service or underserve the patient to meet the goal of the managed care organization. One of the virtues is prudence. In this case, prudence or practical wisdom would lead the physician to modify his service so as to meet the medical need of the patient with the best quality of care obtainable at a more reasonable cost. We like to think that a physician can do this and still remain virtuous.

Loyalties and conflicts

The physician's loyalties are divided among the needs of his or her patients, the needs of all the patients served by the system, the plan's economic directives and his or her own self interest. The resulting conflicts in moral and legal obligations are complex and as yet unresolved.

Guidelines for ethical behavior

The physician's ethical responsibility is to provide care with integrity to the member of the managed care plan in a respectful and compassionate way.

Recent guidelines for clinicians have been published by the Midwest Bioethics Center at Kansas City, Missouri.

According to these guidelines, the physician has a responsibility to:

- 1) Respect members rights.
- 2) Disclose to the member treatment options not covered by the plan which may benefit the member.
- 3) Give priority to clinical and scientific information over financial data.
- 4) Adhere to the plan's standards of care or, where the physician judges the standards not to be in the individual member's interest, to advocate another treatment option to the plan.
- 5) Provide information so that the member can give informed consent for treatment: when the member is unable to participate in decision making, solicit consent from an appropriate surrogate.
- 6) Encourage and assist members to make advance directives and assure that directives are honored within the confines of state law.
- 7) Educate and encourage members to maintain health and use preventive and early intervention services.
- 8) Educate and encourage members to use the plan's resources prudently, in a manner that reflects concern for the needs of all the plans members.
- 9) Use prudently the resources allocated by the plan.
- 10) Participate in allocation policy development for the plan and practice within the plan's allocation guidelines.
- 11) Participate in the development and revision of clinical guidelines and standards of care.
- 12) Participate in the collection of outcome and quality assurance data.
- 13) Participate in the selection and credentialing of providers.
- 14) Speak out and resist when unethical practices are being pursued by peers, purchasers, or the plan. It is not enough to quit the plan: the physician should also work to see that the practice is ended.

"... the virtuous person is someone we can trust to act habitually in a 'good' way... The physician, before he is anything else must be a virtuous person."

Continued on following page

Continued from previous page

15) Treat members without regard to reducing the physician's financial exposure of maximizing the physician's gain.

16) Permit the member to have access to the member's medical records and to explain all information contained in such records.

17) Keep confidential all communications and records related to care except for those persons who have a need to know because, for example, they are participating in the delivery of care, in quality assurance or in resolving claims or grievances.

18) Deny access to employers and other payers to clinical information about an individual member unless permission of the member is obtained, except where otherwise provided by law.

19) Conduct care discussion, consultation, examination and treatment discreetly in order to respect personal privacy.

Living up to all of these guidelines is a tall order for physicians. In fact, the doctor who does will be a paragon of virtue. Still, they are within reasonable reach of attainment in practice.

New ethical challenges

In a broader context than the care of the individual patient, the virtuous physician must confront new ethical challenges. These include the stance of the profession toward state sanctioned capital punishment (should the physician be any where near the execution chamber?) and toward legislative approval of physician assisted suicide or aid in dying. (Can an ethic of "do no harm" be reconciled with such an act?)

At the same time, as US medicine undergoes its most profound reorganization to date, physician self-interest is directly pitted against the well being of patients.

Physician leadership key

Physician leadership is needed to preserve the positive aspects of managed care, to eliminate features that jeopardize patient well being and

to promote a system that emphasizes health outcome over financial reward.

Unfortunately, the physician may take the risk of having his contract not renewed by the managed care organization, when he is pursuing a course which he regards as a virtuous position. Prudence is the required virtue in this setting. As Aaron Rosanoff has so elegantly put it many years ago, in the ethical side of our nature three motivating principles can be distinguished, each of which influences our conduct in a measure which differs in different individuals.

The first of these may be termed pure or aesthetic ethics; it is represented in the saying, "I would rather be right than be president."

The second principle may be termed ethics of prudence; it is represented in the saying, "Honesty is the best policy."

The third principle, which may be termed imposed ethics, has its roots in the deterrent force of such measures of redress, retaliation or protection as are available to individuals and society in dealing with antisocial personalities. A person actuated by this principle has no aesthetic aversion to unethical behavior; and he regards the maxim of prudence with cynicism.

There will not be many instances when the third principle will be applicable to the medical profession. However, the decision to abide by pure ethics of prudence could well be a source of torment to a physician in a managed care setting in certain situations. The saying, "Virtue is its own reward," would be small comfort to one who may be faced with no renewal of his contract in response to a particular stance he might take on a critical issue. This is likely to be one of the "Doctor's Dilemmas" of the late 1990's. ■

Doctor Caldwell is a member of the emeritus medical staff, Nephrology and Hypertension, Henry Ford Medical Center, Detroit. He serves on the MSMS Committee on Bioethics.

The MSMS

Committee on

Bioethics encourages individual members to express their views on prevailing issues in medical ethics to help foster debate and discussion among MSMS members.

If you have encountered a

clinical incident of an

ethics-related issue

when dealing with a

managed care plan

and would like the

Bioethics Committee

to discuss it, please

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Committee Chair

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MD, at (517) 337-

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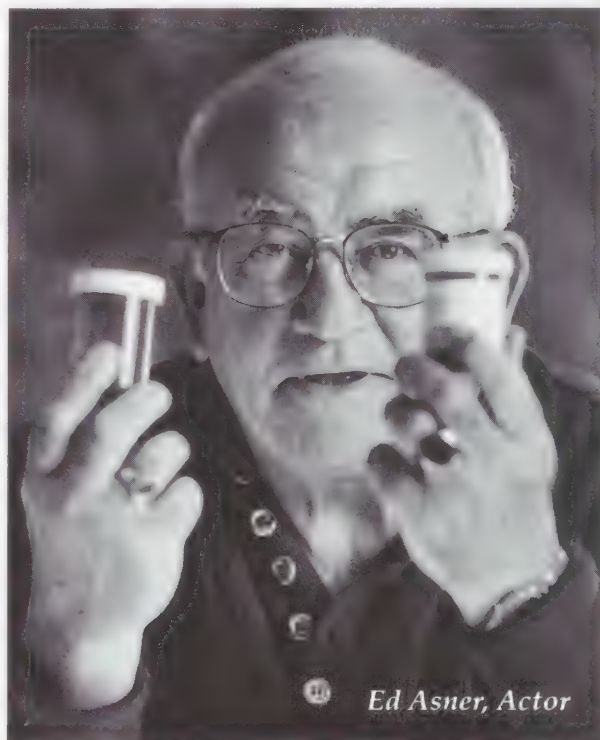
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Lawsuits can rob us of careers

Take steps to protect yourself

By Louis L. Constan, MD

Most of us have heard about the doctors who have been prosecuted and given jail sentences for errors made when practicing medicine. One mistakenly ordered enteral feeding given via a peritoneal catheter. Another misread a Pap Smear.



In both circumstances the patients died, a great deal of publicity occurred, and local prosecutors took the cases to criminal court. Not too long ago, a Midland doctor went to jail for doing an "improper" pelvic exam. What goes on here? Aren't the injured parties just supposed to sue for several million dollars, and console themselves with the money? Apparently, in these cases money didn't seem to be sufficient. Angry family members, aggressive media people looking to get their Pulitzer, local district attorneys trying to make their reputations — all combined to put well meaning doctors, not much different from you and I, behind bars.

Have a story you would like to share? Members of the MSMS Committee on Physician Well-Being invite you to submit your thoughts or experiences regarding physician well-being. Send your materials to: Michigan Medicine, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to bmcnerney@msms.org.

These doctors were publicly humiliated, their practices ruined, their careers effectively ended... just like that.

Why? We may never really understand this sort of thing, it just happens sometimes.

So, what can we do? We certainly should give support to our colleagues. We know that making mistakes is

only human. We know that, with the complexities of modern practice, mistakes are inevitable, and that all of us will make them. We now know that,

when we do make a mistake, in addition to losing time and money, we may lose our freedom, our career. It is my opinion that we'd better get used to this idea, and take some simple measures to prepare ourselves should it happens to us. As you may

suspect, I have some suggestions:

- Don't give your heart and soul to your profession. You need breadth in your life, as well as depth. You need friends (not just doctors), and activities that give enjoyment.

- Spend time with your family. You may need them to stand by you when no one else will. You won't get that kind of loyalty by neglecting them.

- Go to church. It's surprising how many doctors neglect the spiritual side of their lives. You need to get in touch with a higher being who can give meaning beyond daily chaotic events. You may be in a situation where no mortals believe you, and your only comfort comes from supernatural means.

- Don't live beyond your means. Don't spend too much money and go into debt expecting that your income will continue at it's present level. Save some money for that "Rainy Day."

- Practice a little humility. Patients are angered more than anything by apparent arrogance. It seems an American trait to "bring down the mighty." People love to do it and to see it done. Don't make yourself a target.

- Contribute to your community. Join your Kiwanis club. Serve on school committees, run for public office. You may need community support yourself someday. You don't have time? You may find yourself with plenty of time later on. ■

Doctor Constan is a Saginaw family physician and current editor of The Medical Bulletin, the monthly publication of the Saginaw County Medical Society. His article, excerpts of which are printed here, first appeared in The Medical Bulletin.

Joint Section Meeting



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Joint Section Meeting

*March 1-2, 1996
Ritz Carlton Hotel, Dearborn*

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The MSMS evaluation of Michigan health plans
the status of graduate medical education
managed care movements in Michigan

and featuring keynote speaker
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Alabama family physician
first young physician member of the AMA Board of Trustees

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*— Jaak M. Pahn, MD
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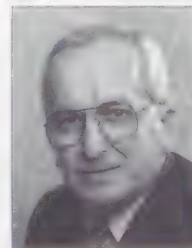
Medicare:

Number 1



Of all the history-making changes occurring in today's health care environment, the upcoming changes to Medicare have received the most public attention by far, and understandably so. Recognizing the complexity of the changes before us, the MSMS Group Insurance Trust introduces a monthly analysis to help us understand the profound changes in Medicare and the impact these changes will have on the practice of medicine in Michigan. The MSMS Group Insurance Trust is pleased to present the first Medicare: Critical Analysis which offers an overview, and establishes the background for what will follow.

*-Earl G. Moehn, MD, Chair
MSMS Group Insurance Trust*



Medicare: Into an Uncertain Millennium

Imagine this: A government program that, on balance, works. A program favored not only by the people who receive its services, but also by the taxpayers who fund it.

Now image this: While other obscure and less popular government programs may evade the budget-balancing cleaver, this popular program must be changed decisively.

Welcome to the strange reality of Medicare as the millennium approaches.

Medicare has accomplished much of what it set out to do when it was signed into law in July 1965 — guarantee coverage for most health services for America's senior citizens. Before Medicare, only half of the elderly had health insurance; with Medicare, virtually every person aged 65 and over is covered, as are persons with disabilities. Beneficiaries defend the program passionately; grudgingly at times, physicians, hospitals and taxpayers uphold its value. They understand that they depend on the program, if not now, then when they reach the golden years. Perhaps only Social Security is held in higher esteem among government programs.

Why Medicare must change

Medicare is held in such esteem because it gives so many people much of what they want. Sadly but inevitably, what we want now costs too much. In 1995, Medicare, which is funded entirely by the federal government, spent roughly \$176 billion for 37 million beneficiaries. Program costs have been rising an average of 10 percent annually. At this rate, by 2005, Medicare will cost \$458 billion, or 19 percent of the federal budget, up from 12 percent of the budget in 1995.

Despite the political bickering, most Democrats, Republicans, and objective analysts agree that this rate of growth cannot be sustained. Demographics play a key role: There simply are too few workers to foot the bill for the growing elderly population. Moreover, the elderly are living longer and elderly (men) are working less, which means that more people are relying on Medicare for more years.

The trustees of the Medicare Trust Fund, which finances Part A care (hospital, skilled nursing, home health, and hospice) from a 2.9 percent payroll tax split by employers and employees, predict

(continued on following page)

Critical Analysis



**Michigan State Medical Society
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that the fund will be bankrupt by 2002. Also, 69 percent of Medicare Part B (physician and outpatient hospital services and tests) is funded by general tax revenues, and taxpayers cannot continue to assume rising program costs. (Most people assume that beneficiaries fund Part B, but their monthly premiums account for only 31 percent of the tab.)

How does politics intersect with these numbers? The Republicans have declared raising taxes and cutting Social Security off the table in negotiations to balance the federal budget by 2002. A big and rapidly growing program, Medicare is the most conspicuous target for cuts. Both Democrats and Republicans concede that cuts are needed, but they have disagreed on their magnitude. Most Democrats believe that Republicans are using Medicare cuts to help finance a \$200 billion-plus general tax cut. Republicans argue that they are not, and that the budget cannot be balanced without dramatic cuts to Medicare.

Is cutting Medicare, then, a "political" decision? Of course. Congress and President Clinton could cut Social Security instead. But they have agreed that Medicare (Medicaid) spending must be brought under control in the next decade. If not, health care costs will overrun the federal budget, prevent budget balancing, and limit funding for other important programs. On this, the bottom line, there is little disagreement.

How Medicare will change

These changes promise to be profound. In many ways that may not be clear for years, they will alter the way that health care is delivered in our country. Because Medicare accounts for nearly 20 percent of the nation's health care costs, its changes will affect the delivery of health care in the private health insurance market, just as prospective payment and the resource-based relative value scale did.

Are these changes the result of actual cuts to Medicare? No, not literally. Medicare funding will continue to grow in the years ahead, on average 6.4 percent a year instead of the current trend of 10 percent. This, however, will feel like a cut to everyone.

Medicare's most significant changes include:

- Beneficiaries will pay higher premiums for Part B. To limit the share of Part B costs borne by taxpayers in general (69 percent in 1995), premiums will increase each year from 1995's \$46.10 per month. Also, higher-income Medicare beneficiaries will pay even higher premiums.
- Beneficiaries, depending on where they live, may have a greater choice of health plans. They can continue in traditional fee-for-service Medicare, with the freedom to choose almost any physician. Or they can opt for managed care, a plan offered by a health maintenance organization (HMO) or a provider service network (PSN). The latter is a community-based delivery system organized and run by physicians, hospitals, or both. With managed care, beneficiaries will likely have to choose from a limited panel of physicians and hospitals. In return, however, HMOs and PSNs may offer more benefits than traditional Medicare to attract patients to their plans.

We should not lose sight of the fact that Medicare was not perfect before the monumental changes of 1995. Medicare did not cover much long-term care or outpatient prescription drugs. Deductibles and copays on most services helped drive Medicare patients' out-of-pocket expenses to nearly \$3,000 a year in 1993. In most cases, these circumstances will not change for beneficiaries.

Preview of future Critical Analyses

In the months ahead, the MSMS Group Insurance Trust Critical Analysis series will delve into a variety of pertinent topics, including:

- the effect of Medicare changes on beneficiaries, actual and prospective
- managed care
- Medigap policies
- Medicare as a secondary payer
- the nuts and bolts of enrolling in Medicare
- long-term care
- options for health insurance coverage for physicians' families their employees.

The long haul

In 2010, the baby boomers will begin turning 65, and the struggles with Medicare we face today will pale in comparison. Still, the upheaval of the past year may prove essential for a program whose importance is, despite its flaws, rarely disputed. We are embarking on a great experiment to preserve Medicare without making it far less than what it was: Coverage for protection against many of the health threats of advancing age.

In these changing times it's important to plan ahead. MSMS Group Insurance Trust representatives will be glad to discuss protection for your future, your finances and your family:

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Up Close: MICHIGAN HEALTH PLANS

MSMS Study will benefit both physicians and patients

The Michigan State Medical Society is in the process of conducting a comprehensive evaluation of Michigan Health Plans. Scheduled for release in March, the evaluation will offer physicians the information they need to make informed decisions about their health plan options. It also will help patients make more informed health insurance choices. The following article provides a concise outline of the goals and objectives of the evaluation.

Choosing a Health Plan?

With so many variables to consider, it's smart advice to look before you sign

By Mary Anne Ford

The Michigan State Medical Society is conducting an evaluation of Michigan health plans to examine the policies and practices of Michigan health plans from the perspective of physicians and their patients. The evaluation, which will be released in March, grew from recommendations of a 1995 MSMS Task Force to Evaluate Priorities with Third Party Payers.

Using information obtained from the plans and from state regulatory agencies, it will provide important information that will enable physicians to make informed decisions about their relationships with Michigan's health plans.

Evaluation highlights

The evaluation will provide information on Michigan's licensed HMOs and health insurers. It will focus on eight major areas that affect the business relationship between physicians and health plans and the physician-patient relationship.

Corporate history

Participating agreements and managed care contracts merit careful evaluation by physicians. Such evaluation requires careful legal analysis, but knowledge of a plan's financial stability and history is equally important. Who owns the plan? Is it financially stable? How much of its premium dollar is actually spent on providing health care services? What geographic areas are covered by the plan and what major employer groups does it serve?

Using information filed with the Michigan Insurance Bureau, the MSMS Evaluation of Health Plans will include detailed information that will help physicians conduct due diligence in decisions about participation. The evaluation also will examine the role of physicians in plan governance and policymaking; and provide an overview of the different kinds of coverage -

HMO, preferred provider, point of service or traditional - offered by each plan.

Quality

As our own efforts to evaluate health plans evolve in future years, MSMS may be able to develop specific measures of quality. For this initial evaluation, we will examine the systems used by health plans to monitor quality; and the results

of recent reviews by the Michigan Insurance Bureau, the Michigan Department of Public Health and the National Council of Quality Assurance. Other areas of this year's evaluation, including physician qualifications and utilization management, will offer insights into quality of care.

Physician qualifications

Choice of physician continues to be a major concern of patients when selecting a health plan. For physicians, the process for physician selection and credentialing is a pivotal concern.

The MSMS Evaluation of Health Plans will examine the selection and credentialing criteria used by health plans. Information on existing physician networks will be provided, including the primary care to referral physician ratio and the percentage of currently participating physicians who are board certified.

Utilization management

Last year, MSMS developed Principles for Utilization Management and Medical Review that will be used to assess utilization management programs. The MSMS principles emphasize the importance of educational implementation of utilization management programs, provide specific guidance on the development and implementation of review guidelines and stress the need for review by practicing physicians of the same specialty as the physician under review. All areas of utilization management will be stud-

Participating
agreements
and managed
care contracts
merit careful
evaluation by
physicians.



ied, including profiling, prospective and retrospective review programs, and formularies.

Appeals and grievance procedures

A vital component of the MSMS Principles for Utilization Management and Medical Review is the availability of a timely, efficient and impartial process to appeal health plans' decisions relating to the review process. The process for patient and physician appeals on these and other issues will be explored, along with current and past experience with appeals and grievances.

Benefits and coverage limitations

Despite the best educational efforts of health plans and employers, few people pay attention to specific limitations of their health insurance coverage — until they require service. Your patients are likely to turn to you or your office staff for information about their health insurance benefits: If I change coverage, will my existing condition be covered? Will I be directed to specific facilities for diagnostic services or mental health services? Can I continue to see you if you are not part of the network?

The evaluation will examine the major features of each of the plan's benefit offerings. It also will explore the process used to approve new procedures for coverage and for benefit interpretation when a patient requires specific services. Finally, we will examine the methods used by each plan to communicate with patients about benefits and changes.

Reimbursement

Even as managed care grows in Michigan, capitation represents just under 20 percent of physician payments. The evaluation will examine the development and implementation of payment and incentive methods - capitation, fee for service and various risk sharing arrangements -

used by Michigan's health plans. Payment rules and policies, like bundling of services or site of service differentials, also will be reviewed.

Administrative efficiency

Physicians and patients alike are concerned with the effectiveness of health plans in dealing with day-to-day issues of claims processing inquiries, verification of eligibility and benefit information, and documentation requirements. Our review will evaluate the administrative efficiency of Michigan's health plans in these areas.

Using the evaluation

A primary goal of this major MSMS effort is to provide our members with an objective source of information about health plans.

Many policies and programs implemented by Michigan health plans respond to specific requests of their customers. MSMS recognizes that positive changes can only be generated through dialogue and partnerships with purchasers and patients, along with physicians and payers.

The evaluation will be a tool for MSMS to use in outreach to patient groups, business coalitions, major employers, labor unions and state policymakers. It's March release will be accompanied by release of a patient-oriented brochure on choosing a health plan and an update of the 1994 MSMS Review of the Health Status of Michigan Citizens. State and local briefings about the evaluation are planned, involving representatives of all these segments of the health care community.

The MSMS Evaluation of Michigan Health Plans offers an unprecedented opportunity for organized medicine to highlight programs that work well for physicians and their patients; to identify areas that need improvement; and to reinforce our leadership in health care decisions. ■

A primary goal of this major MSMS effort is to provide our members with an objective source of information about health plans.

The author is manager of the MSMS Department of Medical Economics and Health Care Delivery.

Clarification

An article entitled "To Be or Not to Be an Employed Physician" appeared in the August, 1995 edition of Michigan Medicine. In that article, a Bay City physiatrist made certain statements regarding her experiences as an employed physician. Some of the statements deserve clarification. The physiatrist did not start the rehabilitation unit at the hospital. It was in operation when she became employed. The statement that the hospital made no accommodation for cross-coverage was meant to reference the physiatrist's specialty only. The statement that the rehab unit essentially placed all of the burdens on one physician should also be clarified. Other doctors provided for patients' medical needs, but she was the only physiatrist available to provide for their rehabilitative needs. The hospital also states that the doctor quoted in the article was not the hospital's first salaried physician, since the hospital employed physicians since 1986. The hospital has advised that another physiatrist was hired effective May 1, 1995. Michigan Medicine regrets any inaccuracies.

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See complete prescribing information in SmithKline Beecham Pharmaceuticals literature or PDR. The following is a brief summary.

INDICATIONS AND USAGE: Engerix-B is indicated for immunization against infection caused by all known subtypes of hepatitis B virus. Immunization is recommended in persons of all ages, especially those who are, or will be, at increased risk of exposure to hepatitis B virus.

CONTRAINDICATIONS: Hypersensitivity to yeast or any other component of the vaccine is a contraindication for use of the vaccine.

WARNINGS: Do not give additional injections to patients experiencing hypersensitivity after an Engerix-B injection. (See CONTRAINDICATIONS.)

Hepatitis B has a long incubation period. Hepatitis B vaccination may not prevent hepatitis B infection in individuals who had an unrecognized hepatitis B infection at the time of vaccine administration. Additionally, it may not prevent infection in individuals who do not achieve protective antibody titers.

PRECAUTIONS: General: As with any percutaneous vaccine, keep epinephrine available for use in case of anaphylaxis or anaphylactoid reaction.

As with any vaccine, delay administration, if possible, in persons with any febrile illness or active infection.

Pregnancy: Pregnancy Category C: Animal reproduction studies have not been conducted with Engerix-B. It is also not known whether Engerix-B can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Give Engerix-B to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether Engerix-B is excreted in human milk. Because many drugs are excreted in human milk, use caution when giving Engerix-B to a nursing woman.

Pediatric Use: Engerix-B has been shown to be well tolerated and highly immunogenic in infants and children of all ages. Newborns also respond well; maternally transferred antibodies do not interfere with the active immune response to the vaccine.

ADVERSE REACTIONS: Engerix-B is generally well tolerated. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions.

Ten double-blind studies involving 2,252 subjects showed no significant difference in the frequency or severity of adverse experiences between Engerix-B and plasma-derived vaccines. In 36 clinical studies a total of 13,495 doses of Engerix-B were administered to 5,071 healthy adults and children who were initially seronegative for hepatitis B markers, and healthy neonates. All subjects were monitored for 4 days post-administration. Frequency of adverse experiences tended to decrease with successive doses of Engerix-B. Using a symptom checklist,* the most frequently reported adverse reactions were injection site soreness (22%), and fatigue* (14%). Other reactions are listed below:

Incidence 1% to 10% of injections: Induration; erythema; swelling; fever (>37.5°C); headache†; dizziness.*

Incidence <1% of injections: Pain; pruritus; ecchymosis; sweating; malaise; chills; weakness; flushing; tingling; hypotension; influenza-like symptoms; upper respiratory tract illnesses; nausea; anorexia; abdominal pain/cramps; vomiting; constipation; diarrhea; lymphadenopathy; pain/stiffness in arm, shoulder or neck; arthralgia; myalgia; back pain; rash; urticaria; petechiae; erythema; somnolence; insomnia; irritability; agitation.

Additional adverse experiences have been reported with the commercial use of Engerix-B. Those listed below are to serve as alerting information to physicians: Anaphylaxis; erythema multiforme including Stevens-Johnson syndrome; angioedema; arthritis; tachycardia/palpitations; bronchospasm including asthma-like symptoms; abnormal liver function tests; dyspepsia; migraine; syncope; paresis; neuropathy including hypoesthesia, paresthesia, Guillain-Barré syndrome and Bell's palsy; transverse myelitis; optic neuritis; multiple sclerosis; thrombocytopenia; eczema; purpura; herpes zoster; erythema nodosum; conjunctivitis; keratitis; visual disturbances; vertigo; tinnitus; earache.

Potential Adverse Experiences: In addition, certain other adverse experiences not observed with Engerix-B have been reported with Heptavax-B®† and/or Recombivax HB®‡. Those listed below are to serve as alerting information to physicians: dysuria.

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NDC 58160-859-01 (package of 1)

10 mcg/0.5 mL in Single-Dose Prefilled Disposable Syringes with 1-inch 23-gauge needles.
NDC 58160-859-05 (package of 5)

10 mcg/0.5 mL in Single-Dose Prefilled Disposable Syringes with 5/8-inch 25-gauge needles.
NDC 58160-859-06 (package of 5)

*Parent or guardian completed forms for children and neonates. Neonatal checklist did not include headache, fatigue or dizziness.

†plasma-derived, Hepatitis B Vaccine, MSD.

‡yeast-derived, Hepatitis B Vaccine, MSD.

Manufactured by **SmithKline Beecham Biologicals**, Rixensart, Belgium
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Immunizing Michigan's Children

MSMS joins campaign to improve state's pitiful record

How to fully immunize 90 percent of Michigan's children aged two and under brought together more than 60 representatives from health care and other concerned groups at a meeting held late last year at MSMS headquarters in East Lansing. They shared stories about what they're doing now on their own, and talked about ways the groups might link their efforts.

The Michigan Department of Public Health hosted the meeting as part of a campaign to meet and permanently sustain the 90 percent immunization goal. A recent study by the Centers

for Disease Control and Prevention showed that only 61 percent of Michigan two-year-olds in 1994 had been fully immunized.

An Immunizations Summit will be held January 31 at the Hannah Ballroom in East Lansing from 10:00 a.m. to 3:00 p.m. MDPH reports that nearly 300 people already are planning

to attend this meeting, including Michigan Lieutenant Governor Connie Binsfeld.

For more information on this summit, contact Christine Shearer at MSMS at (517) 336-5737.

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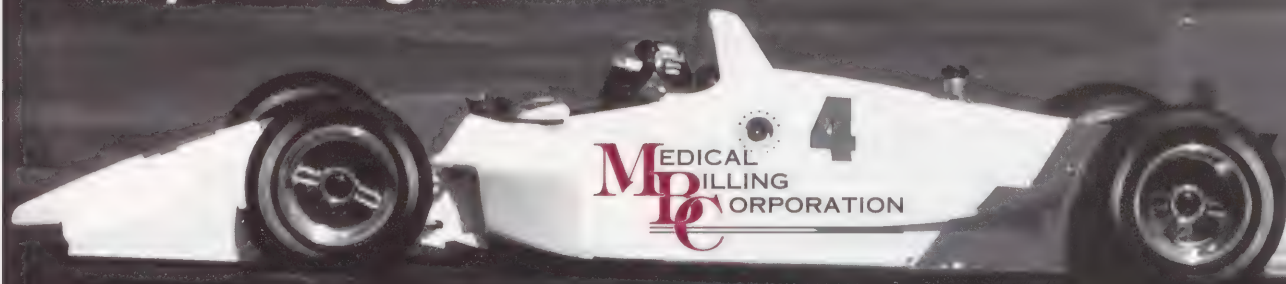
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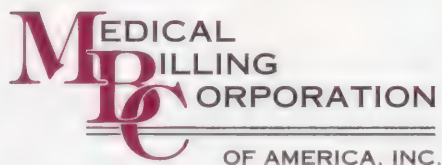
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Family Limited Partnerships:

It's worth taking a second look

By Steven J. Shanker, CPA, ASA

Many physicians whose estates are significant have yet to take full advantage of family limited partnerships. They should make it a point to explore this relatively new estate planning vehicle with their attorney and/or CPA.

These partnerships enable parents to: 1) shift assets to their children or other heirs, thus lowering estate taxes; 2) do so usually at a discount of face value, thus each year transferring to individual children assets worth up to 42.8 percent more than \$10,000 without being subject to gift taxation; and 3) still retain control over the assets.

Given these advantages, it is surprising that such partnerships are not more widely used.

The family limited partnership structure allows physicians (and others) to consolidate all or some of their assets into a single entity, manage the assets in an orderly fashion and make gifts of interest in the entity as a whole rather than transfer the assets piecemeal.

What can be included in such partnerships? The family business, real estate, marketable securities, other property — all of these have

touched.

The general partners set out the terms of the limited partnership agreement: management of the partnership assets, the conditions under which the partnership may be dissolved, distribution of cash flow among the various partners and restrictions on sale or transfer of partnership interests.

Since limited partners cannot control the entity, their interests are not easily marketable and the face value of the interests are discounted. As a result, given a

30 percent discount, interests with a face value of \$14,285 and a discounted value of \$9,999.50 can be transferred each year to as many heirs as desired — each one receiving that amount — without being subject to the uniform gift and estate tax.

This permits a couple to transfer up to \$28,750 a year to as many heirs as desired — each one receiving \$19,999.00 — and substantially reduce the amount of time otherwise required to transfer the assets.

While the IRS considers the family limited partnership a legitimate estate planning method, there should always be a professional valuation of the assets and the partnership to ensure that the values are sustainable under IRS challenge.

Use of such a partnership estate planning method is especially interesting in cases where the assets are appreciating rapidly and the time frame to transfer the assets can be compressed. ■

Steven J. Shanker, CPA, ASA, is managing director of Shanker & Stout Valuation Consultants, Inc., Farmington Hills, which provides asset and business valuation for professional firms and businesses.



been included in the past. The test is providing a valid business purpose. The partnerships are not limited to parent/child combinations and work best when the heirs are young.

As general partners, the parents retain control over the assets. As limited partners, the children have limited liability and the assets cannot be

"The partnerships are not limited to parent/child combinations and work best when the heirs are young."

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Raj Bothra, MD

From healer to presidential appointee, he is a man committed to numerous charitable causes

By Karen Bouffard

A large piece of Raj Bothra, MD's life is spent half a world away from the Birmingham, Michigan, home he shares with his wife, Pammi, and six-year-old daughter, Rimjhim.

It's spent far away from England, where he became a Fellow of the Royal College of Surgeons in 1970. Far from Detroit's Mt. Sinai and Highland Park Hospitals where he completed surgical residencies in the early '70s. And far from Holy Cross Hospital where he became chief of surgery in 1988, serving as chief of the medical staff from 1990 to 1993.

About eight weeks of each year Doctor Bothra leaves his general surgery practice in Warren and travels to his native India at his own expense to minister to the poor, the AIDS stricken, the alcoholics and drug addicted of Bombay.

Sometimes Doctor Bothra does this with his sleeves rolled up, visiting the red light districts to educate prostitutes on how to protect themselves and their clients. Sometimes he's in a suit,

serving as a presidential appointee to India's National AIDS Committee; working with Parliament members and government ministers to help shape public health policy. Often he's in black tie, raising money for countless charitable causes. And at times he puts on his walking shoes, as when he walked 100 miles from Ludhiana to Amritsar to demonstrate for peace in Punjab in 1987.

A lecturer, writer, fundraiser

Equally tireless in the US, Doctor Bothra spends his time in the States lecturing, writing and fundraising for his causes. He was founding president of the Nargiss Dutt



Doctor Bothra has worked with Mother Theresa to solve India's social problems. He, along with his wife Pammi, adopted their daughter, Rimjhim, from one of Mother Theresa's orphanages.

Foundation, named for a famous Indian actress and philanthropist who sought treatment in the US 25 years ago before dying of pancreatic cancer. The Foundation has purchased major equipment for hospitals in India, and has worked with other organizations to build a new hospital to replace one destroyed in a devastating earthquake that hit the town of Latur, Maharashtra in 1993. Doctor Bothra also is the president and founder of the India AIDS Foundation (USA), and is an active member of the governing body of the American Association of Physicians from India.

His wife Pammi spends her time nurturing little Rimjhim—who weighed just 11 pounds when she was adopted from one of Mother Theresa's orphanages at 10 months—and has opened her home to a VIP list of legislators, business leaders and celebrities with either the power to influence policy or the resources to back Doctor Bothra's worthy charitable causes.

One such contact, U.S. Representative James McDermott, D-Wash., chair of the Congressional International AIDS Task Force, has been instrumental in focusing US and world attention on India's AIDS crisis. Following McDermott's visit to Bombay, at Doctor Bothra's urging in 1987, the World Health Organization contributed \$85 million to fight AIDS in India. In all, Doctor Bothra's campaigns have raised more than \$1 million for medical facilities, equipment and training in India.

"There are so many problems. What we do is so small," says Doctor Bothra, who's work has brought numerous honors, including the Medal of Merit which was presented to him by US President Ronald Reagan.

Doctor Bothra writes dozens of articles for both Indian and US publications on subjects including the AIDS pandemic, Indo-American relations, US domestic and foreign policy and India's domestic concerns. He holds regular lecture tours in India, educating professional and lay audiences on health issues. And he has held discussions on social issues with world and

religious leaders, including Indian Prime Minister Narsimha Rao, former Indian Prime Minister Rajiv Gandhi, former US President George Bush, Pope John Paul II and Mother Theresa. There is a sense of urgency about his work.

"Social/medical problems, AIDS, drug abuse, alcohol abuse—these are all totally correctable problems which you can do something about by educating people," he says, noting that 10 million people in India may be infected with HIV within the next 10 years.

"India has 1.5 million people infected right now. One point five million people are going to die at age 20 to 40. What we can do is prevent further infection of another 10 million people."

"We are running out of time."

As a native of India, Doctor Bothra is acutely aware of unique characteristics that make public education there more difficult. The country has more than a dozen major languages, with thousands of dialects, making mass media ineffectual. Pamphlets, brochures and other print communication is only marginally effective, given rampant illiteracy. Only recently has television become sufficiently penetrated to warrant large-scale use in public health campaigns. Eager to take advantage, Doctor Bothra has worked with the Nargiss Dutt Foundation to produce two documentaries on AIDS, and is planning another on tobacco abuse.

"When you are educating an entire population, it is not a matter of a month or a year, but of many years," he says, adding that he hopes all physicians will become involved in volunteerism.

"We are the blessed ones who are able to do it," he says. "If we do not do it, who will?" ■

The author is a Williamston, Michigan-based freelance writer.

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Janice L. Werbinski, MD

A crusader for women physicians

By Karen Bouffard

Janice L. Werbinski, MD, studied medicine at a time when few women did. By the time she graduated from Milwaukee's Medical College of Wisconsin in 1975, she'd learned to be "one of the boys."



"I can remember saying sexist jokes, because it would make me fit in," she recalls. "There's a whole culture you become part of in medical school. If you didn't become 'one of the boys' you were 'different'."

These days, as medical director of the Center of Women's Health at Kalamazoo's Bronson Methodist Hospital, and chair of the MSMS Committee on Concerns of Women Physicians, Doctor Werbinski sometimes finds herself 'deculturizing' female colleagues.

"I try to teach them to unlearn some of those culturized things," she says. "They sometimes have to learn that it's OK to bring in your femininity, to be yourself. It's my patients who have taught me that."

Doctor Werbinski, 48, grew up in Marion, Ind., and Kalamazoo, where her family moved to live near the GM plants where her father worked. Her parents, children of Polish immigrants, en-

couraged her to become a doctor, but Doctor Werbinski initially believed that medical school would be too long a commitment and too expensive.

But in her heart, Doctor Werbinski always wanted to be a doctor: As a child, her favorite

TV show was "Medic," featuring live operations on real patients; she kept a log about her pet caterpillar; her sister thought she was crazy for dissecting a tree toad. After graduating with honors from Western Michigan University in 1968, Doctor Werbinski moved to California where she worked as a med tech for two and a half years, saving money for medical school.

Marriage had to wait

She met Clarence, a Kalamazoo trucking and roadbuilding entrepreneur, while studying at the Medical College of Wisconsin. In order to live close to him, she took her residency at Lansing's Sparrow Hospital. "I refused to marry him until I was finished, so he waited five years," Doctor Werbinski recalls. "I didn't want anything to get in the way of graduating." She finished her residency in October 1978, and they married the following May.

"I wrote to every ob/gyn in the Yellow Pages, and nobody in Kalamazoo chose to hire me," she recalls, adding she'd chosen to practice obstetrics and gynecology because she'd noticed that female patients were drawn to her as a woman physician. "Now many practices are looking for women partners because they can see the business we pull in. Now I enjoy a good reputation due to quality, rather than gender. But in general, women ob/gyns are preferred by women patients."

Doctor Werbinski finally found a job in a private ob/gyn practice in Paw-Paw, about 15 miles outside of Kalamazoo. Five years later, Bronson Methodist asked if she'd like to manage their clinic in Vicksburg, another small town outside Kalamazoo.

"I wanted to be an employed physician," she says. "That is typical. A lot of women don't want to get into the business side of medicine. I never wanted to have my own shingle and my own practice."

After five years in Vicksburg, in 1987, she was asked to direct Bronson Methodist Hospital's new Women's Health Center. "The 'women's center' was a big trend among hospitals at that time," she says. "It came out of the women's movement of the '60s and '70s. Hospitals saw they could use women's centers to get clients into their hospitals."

Bronson invited Doctor Werbinski to attend a conference on women's centers.

"I came back almost proselytizing about women's centers after I saw it as more than just a marketing technique," she says. "I wanted to build something stronger and better than that."

Two key visions

As medical director, Doctor Werbinski's vision is a program that integrates internal medicine, psychiatry, and ob/gyn services in a "total women's health concept." She has a vision too, for the MSMS Committee on Concerns of Women Physicians. As chair, her chief goal is to sharpen the committee's focus.

"The focus has traditionally been on the two major educational seminars the Committee sponsors," she says. "A problem has been that in order to retain eligibility for Continuing Medical Education credit, these have had to deal with issues that have not always focused on the concerns of women physicians."

"We need to refocus the Committee's attention on the needs of women physicians, as distinct from the needs of male physicians," she adds. "I would also like to strengthen the Committee's advisory role within MSMS."

Doctor Werbinski notes that the Committee will hold a women's caucus at the MSMS House of Delegates meeting in May. The purpose of the caucus is to decide on ways to support women

running for public office at the state and national level. The caucus also will discuss and identify women physician's issues that the Committee may want to testify about at the delegates meeting. She encourages women physicians to call her with their input.

Many concerns unchanged

Doctor Werbinski, the mother of two girls aged 10 and 13, says the primary concerns of women physicians are not much different than when she started in medicine: equal pay for equal work; family leave issues, especially in pregnancy; balancing family and career responsibilities; the issues of being employed physicians; and issues such as time, dues and child care that keep women from participating in organized medicine.

Doctor Werbinski notes that the House of Delegates voted last May to approve partial dues for part-time physicians — a cause she had championed because of the large number of women physicians who choose to work part time. The measure was passed with a 'sunset clause': if after two years the number of part-time physician members does not increase, the dues break will be discontinued.

"I would encourage every physician in the state to let all their part-time women colleagues know that this option is now available, and that they will have full privileges of membership," she says. "If we as women don't have a critical mass number of people giving our opinions, those of us who do are in the minority. We have to show up to be heard, and we have to learn the system to be heard."

"The statement I hear most often from women colleagues is 'organized medicine is a good-old-boys group that doesn't represent my issues,'" Doctor Werbinski says. "I'd like our committee to hear those issues so that we can represent them." ■

The author is a Williamston, Michigan-based freelance writer.

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From Medicine to Music

The combination spells foot-stomping success

By William Kendy

To hear some of the best bluegrass music ever produced, you needn't travel further south than Ann Arbor, home of The RFD Boys.

What makes The RFD Boys so unique are its members. Two of the band's four members are physicians. Richard V. Dieterle, MD, chief of pathology at Jackson's Foote Hospital, plays the fiddle. Paul Shapiro, MD, an Ann Arbor physiatrist, plays the bass. The band's other two members are equally unique. Banjo player Willard Spencer, is the owner of a recording studio. Guitarist Charlie Roehrig, PhD, is an economic planner and consultant.

The RFD Boys have been entertaining country music fans for over 25 years, with almost 700 songs in their repertoire.

Talent and tenacity key to success

In addition to talent, tenacity has contributed to the success of The RFD Boys. Formed in 1969, the band has been going strong, despite the hectic professional and business schedules of its members. In fact, when the band had the opportunity to go on tour, its members opted to concentrate on their primary businesses.

"The RFD Boys from Ann Arbor...have been making about the best bluegrass music you'll hear," wrote Detroit Free Press columnist Bob Talbert. Members of the band include: Back row (l to r): bass player Paul Shapiro, MD, and guitarist Charles Roehrig. Front row (l to r): banjo player Willard Spencer and fiddler Richard V. Dieterle, MD.



"We had the usual young men ambitions," says Doctor Dieterle. "We were at the point where we had to start traveling. I was in my medical residency and the other band members had their own important pursuits."

The commitment of the band to its music and each other is impressive. Doctor Dieterle convinced the U.S. Air Force to station him in Dayton, Ohio so he could stay active in the band. For three years, he commuted between Dayton and Ann Arbor to play "gigs." Doctor Shapiro, who attended the Michigan State University College of Human Medicine, drove 60 miles each way, three nights a week to play.

Top notch bluegrass

How good are The RFD Boys? According to The Detroit Free Press columnist Bob Talbert, "the RFD Boys from Ann Arbor...have been making about the best bluegrass music you'll hear."

Doctor Dieterle has an interesting spin on this. "We all had talent, but we weren't blow-you away talent. There were better fiddle players. There were better banjo players. There were better singers. There were better writers. But we always got the gigs and we always drew audiences." Doctor Dieterle adds that he has talked to some fans that haven't missed an RFD Boys appearance in 15 years.

And they have played bluegrass music with some of the best, appearing with the likes of Bill Monroe, Allison Krause, Ralph Stanley, Ricky Nelson and Randy Travis. The group has produced three albums, has done a bit of touring and has appeared on the cover of Bluegrass Unlimited, a prestigious country western magazine. Regardless of their hectic daily lives, The RFD Boys are still entertaining their fans. They appear two nights a week at the Ark nightclub in Ann Arbor. Their longevity amazes some of their listeners who remember them from long ago, even when some were in college.

Ten original songs

The RFD Boys have written about 10 original songs, including one called "Sit By The River," written by Charlie Roehrig and recorded by the Country Gentlemen. The song made its way into the "Bluegrass Songbook."

How much longer does The RFD Boys plan to entertain and write music? "As long as we can or until we stop growing artistically and musically," says Doctor Dieterle.

It's refreshing to know that serious doctors and businessmen can let down their hair and do a little fiddling, strumming, picking, singing and foot stomping. This winning equation all adds up to the RFD Boys.

By the way, RFD stands for Rural Free Delivery.

The author is a freelance writer based in Holt, Michigan.

Comment Line

If you would like to comment on an article in *Michigan Medicine*, or any other aspect of the magazine, please do not hesitate to contact Betty McNerney, Editor of Publications, at (517) 336-5749, or by FAX at (517) 337-2490, or E-mail at bmcnerney@msms.org

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Just For Kids

Kids help educate future physicians at MSU College of Human Medicine

By Karen Bouffard

Every week for the past six months, Cherie Self, a busy second-year student in MSU's College of Human Medicine, has taken time out from her studies to spend two hours with a tiny four-year-old girl who has cancer.

Cherie and her "Buddy," Karsha Schrems, Michigan State University student-run program called "Just For Kids." The program was initiated in 1994 by a small group of students active in MSU's American Medical Association Student Section. The program took one year to develop and now has 17 student participants.

"It gives students a chance to take information that can be very vague, and integrate it into real life situations," says student Yanna Karabatsos, who initiated the program and recruited others to get involved. "We wanted students to feel the satisfaction of seeing real patients, and to experience how an illness affects a child and their family."

How the program works

According to Yanna, chronically ill children in kindergarten through grade twelve are recommended for the program through their physicians at the MSU Clinical Center's Chronic Care, Pulmonary, Endocrine or Hematology/Oncology clinics. An initial meeting of the parents, child and

student is arranged by the physician, and occurs in the clinical setting. After that, it's up to the student and family to arrange future meetings in the clinic, hospital or home.

Students make a commitment to stay with the program for at least one year, and to make some contact with the child at least once per week. They also promise to spend three to four hours every two weeks with their assigned child.



Cherie Self (right), a second-year medical student at the MSU College of Human Medicine, spends time with her "Just For Kids" program buddy, Karsha Schrems, a four-year-old cancer patient who is now in remission.

At first their visits were at the hospital, but now that the cancer is in remission they visit at the child's home.

"What we do depends on her energy level," Cherie says. "Sometimes we do artwork; yesterday we even sang! She has quite an imagination — I don't have to be very creative. She knows just what she wants to do."

"I've come to realize the importance of being a reliable and consistent person in Karsha's life so that we can develop trust," says Cherie of her program partner. "I'm not a babysitter, not a teacher, not there to make her learn anything. I'm her 'Buddy'." "The uniqueness of the relationship is for her to feel that she's very special. I'm someone who doesn't see that she has no hair."

Many student participants have an interest in pediatrics or family medicine, or past experience working with children. Craig Kozler, "Just For Kids" coordinator, has a Master's degree in marriage and family therapy.

"I wanted experience helping children with the social needs of a critically ill child," Craig says. "A lot of them don't have the peer interaction other children have, and many have physical or mental handicaps." Prior to acceptance in the program, Craig says, medical students go through a brief training and fill out questionnaires about their background, experience and expectations. Parents are given a packet of information that includes details of the program and a questionnaire on issues such as confidentiality, medical considerations, and the child's interests or hobbies. The parent and student questionnaires are used to find a suitable match for each student and child.

A "WIN-WIN" Situation

The group's faculty advisor, Elizabeth Seagull, PhD, a pediatric psychologist and professor in the College of Human Medicine's Pediatrics



Department, calls "Just For Kids" a "win-win" program. "The child gets a friend, and the student gets a chance to get to now how having a chronic illness impacts a child," she says. "It's wonderful that we're turning out doctors that are really interested in the full life of the child — not just as a case but as someone who's in a family, and goes to school, and plays, and all of those things."

Adds Cherie: "For me, what it does is remind me every time I see Karsha why I went into medicine. "It will make me work much harder in the future because I know what they're going through — what the whole family is going through, in dealing with a chronically ill child."



The author is a Williamston, Michigan-based freelance writer.

"It reminds me every time I see Karsha why I went into medicine. I know what they're going through — what the whole family is going through."

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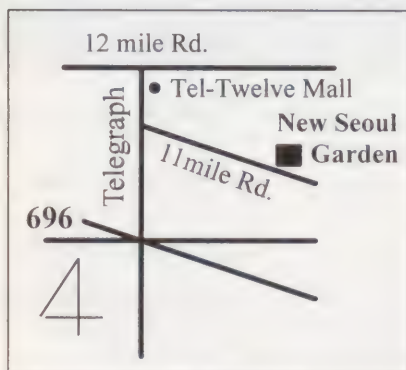
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NEWSMAKERS

Robert Reid, MD, is the newly-appointed vice president and medical director of William Beaumont Hospital, Royal Oak. He had served as the associate medical director of Beaumont Hospital since 1983.

Russ P. Nockels, MD, is the new director of the Neurosurgery Spine and Trauma Program at Henry Ford Hospital, Detroit. Doctor Nockels came to Detroit from the University of California at San Francisco, where he was director of the spinal neurosurgery service and acting chief of clinical neurosciences.

Frank B. Walker, MD, is a newly-named member of the Board of Directors of the Detroit-Macomb



Hospital Corporation (DMHC). A clinical associate professor of pathology at Wayne State University School of Medicine

and former corporate director of laboratories for DMHC, Doctor Walker is an active member of the American Medical Association Board of Trustees and the Michigan Delegation to the AMA. He is one of only seven AMA represen-

tatives to the Joint Commission on the Accreditation of Healthcare Organizations.

Vivian M. Lewis, MD, vice president of Lewis Medical Services, Flint, is the recipient of the 1995 Athena Award. Doctor Lewis, a private practice pediatrician, was one of 12 women nominated for the annual award which is given to the woman who has contributed the most to her profession and the community.

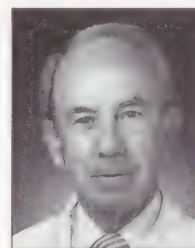
Brooks Bock, MD, chair of emergency medicine at the Wayne State University School of Medicine, and chief of emergency services for The Detroit Medical Center, is the newly-named holder of the Munuswamy Dayanandan, MD, Endowed Chair of Emergency Medicine. The fund for this chair was established in memory of Detroit Receiving's former vice chief of emergency medicine, the late Doctor Dayanandan, who died in 1994.

Larry Stephenson, MD, chief of cardiothoracic surgery at Harper Hospital and professor of surgery at the Wayne State University School of Medicine, is the newly-named holder of the Ford/Webber Endowed Chair in General Surgery. The chair was made possible through the Webber Medical Advancement Fund and the estate plan of Mrs. Beverly Ford. Under Doctor Stephenson's leadership, Harper Hospital and the School of

Medicine have been recognized as a center of excellence for cardiovascular research and clinical services.

John M. Malone, Jr., MD, is the newly-appointed vice president for Academic Affairs for The Detroit Medical Center (DMC), and associate dean of Medical Center Affairs for the Wayne State University (WSU) School of Medicine. Doctor Malone will be working with WSU and the DMC to maintain and improve residency and fellowship programs. Doctor Malone will continue his practice as a gynecologic oncologist at Hutzel Hospital, Detroit.

Charles E. Jackson, MD, Clinical and Molecular Genetics, Henry Ford Hospital, is one of a team of researchers who has identified a



genetic defect that contributes to a type of muscular dystrophy. The finding adds to the growing body of research that

links a cluster of eight proteins common to all healthy muscle. The study, published in the November 6, 1995, issue of *Nature Genetics*, found that the absence of a protein can cause limb-girdle muscular dystrophy.

(continued on following page)

Continued from previous page

John A. Anderson, MD, head of the Division of Allergy and Clinical Immunology at Henry Ford Hospital, is recipient of the Jerome Glaser Distinguished Service Award from the American



Academy of Pediatrics. The award is given in memory of Doctor Jerome Glaser, a noted pediatric allergist, and recognizes outstanding academic, clinical or public service in the field of pediatric allergy and immunology.

James O. Woolliscroft, MD, professor of internal medicine and chief of clinical affairs at the University of Michigan, is the first faculty member at UM to hold the Josiah Macy Jr. Professorship of Medical Education. The New York-based Josiah Macy, Jr. Foundation recently awarded \$2 million to the UM Medical School to endow the professorship. Doctor Woolliscroft will lead a team of medical educators at UM Medical School in the development, implementation, and evaluation of educational models for teaching medical students in ambulatory care settings.

Alfred B. Swanson, MD, a Grand Rapids orthopedic surgeon, has been selected to receive the American Medical Association's

Scientific Achievement Award for 1996. The award recognizes an individual(s) for outstanding scientific work. Doctor Swanson will receive the award, a medallion, at the opening ceremonies of the AMA Annual Meeting, June 23, 1996. ■

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Jodie Bogosmilsky, MD, Detroit

Shannon L. Bongers, MD, Detroit

Alvin L. Bowles, MD, Detroit

Angie Lynn F. Domingo, MD, Saginaw

Modesto Fontanez, MD, Saginaw

Arthur J. Frazier, MD, Detroit

Stanley Frencher, MD, Detroit

Benzion G. Goldwyn, MD, Detroit

Amy I. Green, MD, Detroit

Joel E. Haas, MD, Detroit

Susan H. Hepker, MD, Saginaw

Jeff Hinman, MD, Detroit

Stephen C. Hyman, MD, Bingham Farms

Izabella Ilyasov, MD, Garden City

James J. Jesko, DO, Saginaw

Samasandrapalya R. Kiran, MD, Flint

Banwari Ladha, MD, Franklin

Steven G. Lee, MD, Detroit

Patricia L. Litts, MD, Roseville

Kevin Lobdell, MD, Detroit

John N. Lomas, MD, Saginaw

Tina C. Mason, MD, Detroit

Robert S. Moskalik, MD, Coldwater

Sudha Nallani, MD, Flint

Eric N. Neisch, MD, St. Clair Shores

Todd Y. Nida, MD, Bloomfield Hills

James Peabody, MD, Detroit

Willard O. Perez, MD, Warren

Todd Permut, MD, Dearborn

Parven Qazi, MD, Bingham Farms

Dheeraj Rajan, MD, Detroit

Sunil R. Rangwani, MD, Alma

Mona S. Shah, MD, Saginaw

Nasfat Shehadeh, MD, Allen Park

Richard E. Simpson, III, MD, Farmington Hills

Anvita Sinha, MD, Allen Park

Vineel Sompalli, MD, Saginaw

Varudeyam P. Veluswamy, MD, Pontiac

Thomas D. Villalobos, MD, Grand Rapids

Mary Jo Wagner, MD, Saginaw

Mark T. Williams, MD, Detroit ■

DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Edwin E. Ekong, DO, 16215 Oxley Rd., #202, Southfield, MI 48075

Action, Date Taken: Probation - 3 yrs., 10-05-95

Reason: Criminal Conviction - Insurance Fraud

Name: Alan A. Halpern, MD, 1700 S. Park St., Kalamazoo, MI 49001

Action, Date Taken: By Order of the Kalamazoo County Circuit Court, The Board's Order dated 9-29-95 and effective 10-30-95 is Stayed.

Reason: None Available

Name: Julius Horvath, MD, 229 S. Gratiot, Mt. Clemens, MI 48043

Action, Date Taken: License Summarily Suspended, 10-26-95

Reason: Drug Related

Name: Soren C. Jorgensen, MD, 70 South Howell, Hillsdale, MI 49242

Action, Date Taken: License Summarily Suspended, 10-24-95

Reason: Criminal Sexual Conduct

Name: Joseph H. Ladaga, DO, 515 Main Street, Dowagiac, MI 49047

Action, Date Taken: License Suspended - 6 mo. & 1 day, Fine - \$10,000.00, 11-10-95

Reason: Negligence - Incompetence, Lack of Good Moral Character

Name: Pamela S. Mazzoline, MD, 118 Loree Drive, East Lansing, MI 48823

Action, Date Taken: License Suspended - 6 mo. & 1 day, Voluntary Surrender of Controlled Substance License, 09-20-95

Reason: Drug Related

Name: Todd L. Roellchen, DO, 25097 Woodvalle Dr. North, Southfield, MI 48034

Action, Date Taken: Educational Limited License, Suspended - 1 yr., 11-06-95

Reason: Substance Abuse

Name: David L. Thomson, MD, 7924 Woodingham, West Bloomfield, MI 48322

Action, Date Taken: License Suspended - 6 mo. & 1 day, 10-18-95

Reason: Mental/Physical inability to practice

Name: Tommy Von Lührte, DO, HC 74 Box 443, Vanceburg, KY 41179

Action, Date Taken: License Suspended - 3 mo., Limited License, 10-30-95

Reason: Negligence - Incompetence, Lack of Good Moral Character

Name: James P. Wilson, MD, 18556 E. Long Avenue, Aurora, CO 80016

Action, Date Taken: Reprimand, 10-18-95

Reason: Negligence

MSMS Meetings

January

29, MSMS Alliance. Location: MSMS Headquarters, East Lansing. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

March

1-2, MSMS Joint Section Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Judy Marr at MSMS at (517) 226-5744.

20, MSMS Board of Directors Meeting. Location: MSMS headquarters, East Lansing. Contact: William E. Madigan, Executive Director, at (517) 336-5734.

28, Maternal & Perinatal Health Conference. Location: MSU Management Education Center, Troy, MI. Contact: Sarah Cressman at MSMS at (517) 336-5727.

April

26, MSMS Regional Scientific Meeting. Location: Dearborn. Contact: Sarah Cressman at MSMS at (517) 336-5727.

26-28, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Donna Brown at (517) 336-5735 or Jeanne Miller at (517) 336-5726.

26, 28, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: William E. Madigan, Executive Director, at (517) 336-5734.

29-May 1, MSMS Alliance House of Delegates Meeting. Location: Park Place, Traverse City, MI. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

AMA Meetings

March

10-13, AMA Leadership Conference. Location: Renaissance Hotel, Washington, DC. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty Society Meetings

February

10, Michigan Society of Pathologists. Location: Holiday Inn South, Lansing. Contact: Melissa Wiegand at (517) 336-7586.

14, Michigan Chapter of the American College of Surgeons. Location: Novi Hilton. Contact: Melissa Wiegand at (517) 336-7586.

15, Michigan Ophthalmological Society. Location: Radisson, Southfield. Contact: Andrew Lott at MSMS at (517) 336-7589.

March

6, Michigan Allergy & Asthma Society. Location: Novi Hilton. Contact: Jennifer Anibal at (517) 336-7595.

6, Michigan Dermatological Society. Location: University of Michigan. Contact: Jennifer Anibal at (517) 336-7595.

7-9, Michigan Association of Medical Education. Location: Holiday Inn South, Lansing. Contact: Melissa Wiegand at (517) 336-7586.

13, Michigan Chapter of the American College of Surgeons. Location: Novi Hilton. Contact: Melissa Wiegand at (517) 336-7586.

17, Michigan Society of Medical Assistants Board Meeting. Contact: Caroline Kimmel at (517) 336-7587.

21, Michigan Ophthalmological Society. Location: Radisson, Southfield. Contact: Andrew Lott at MSMS at (517) 336-7589.

April

13, Michigan Society of Anesthesiologists. Location: Ritz Carlton, Dearborn. Contact: Jennifer Anibal at (517) 336-7595.

18, Michigan Medical Group Managers Association Spring Conference. Location: Sheraton Hotel, Lansing. Contact: Andrew Lott at MSMS at (517) 336-7589.



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MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Rural Communities and HIV/AIDS

Conference

May 15, 1996

Grand Traverse Resort, Traverse City

HIV/AIDS has made its way into rural areas and small towns across the country. This growing presence poses a number of new challenges and concerns for health care providers. The Michigan State Medical Society will address many of the concerns confronting health care providers in rural areas of Michigan during a conference titled, "Rural Communities and HIV/AIDS."



Keynote speaker
Abraham Verghese, MD,
author of "My Own
Country: A Doctor's
Story," will share his
experiences of providing
HIV/AIDS care in rural
Tennessee.

This full-day conference will focus on issues including the challenges of providing HIV/AIDS care in rural settings, case management, and legal considerations related to HIV/AIDS. Concurrent sessions will discuss clinical care and medical care issues. And, a panel of persons living with HIV/AIDS will talk about their experiences and challenges they face.

The registration fee for this conference is \$65.

This conference also will be offered as a video conference in a number of sites in Michigan.

For information about CME credits, or to register, please call MSMS at (517) 336-5776.

Financial Supporters and Meeting Planning Committee:

Michigan Department of Public Health
Michigan State Medical Society
Thomas Judd Care Center
Michigan AIDS Fund

Metro Health Foundation
MSU AIDS Education Project
Michigan Center For Rural Health
Michigan Health Council



Michigan State Medical Society
the Voice of 12,000 Michigan Physicians

EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

January

25-26, Colposcopy for the Primary Care Physician. Location: Ashman Court Hotel, Midland, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Jill Frost, 4909 Hedgewood Drive, Midland, MI 48640, 1-800-462-2492. **Approved for:** 15.25 hours of Category I Credit.

26-27, Adolescent Suicide: Assessment, Treatment & Prevention. Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

27, LEEP/LETZ/LOOP. Location: Ashman Court Hotel, Midland, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Jill Frost, 4909 Hedgewood Drive, Midland, MI 48640, 1-800-462-2492. **Approved for:** 6.25 hours of Category I Credit.

30, Managing the Real Inequality Between Co-Therapists. Location: Bar-Levav Education Association, 3000 Town Center, Suite 1275, Southfield, MI 48075. **Sponsor:** Bar-Levav Education Association. **Contact:** Joseph Gluski, MD, (810) 353-5333. **Approved for:** 4 hours of Category I Credit.

February

2-3, Working with Difficult Couples. Location: Topeka, Kansas. **Sponsor:** The Menninger

Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

4-9, The 20th Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsor:** The University of Michigan Medical School, Department of Family Practice, The Michigan Academy of Family Physicians. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

11-16, Twentieth Annual Seminar on Emergencies in Medicine. Location: Boyne Highlands Ski Lodge, Harbor Springs, MI. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours of Category I Credit.

14-16, Review Course in Pain Medicine. Location: Buena Vista Palace in Lake Buena Vista, Florida. **Sponsor:** American Academy of Pain Medicine. **Contact:** American Academy of Pain Medicine, (708) 375-4731.

23-24, Comprehensive Treatment Approaches for Adults with Childhood Trauma Histories. Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

28 - March 2, Advances in the Management of Infectious Diseases: Winter Update. Location: South Seas Plantation, Captiva Island, Florida. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 313-763-1400. **Approved for:** 13 hours of Category I Credit.

March

2-3, Violence: Implications for Clinical Practice. Location: The Royal Sonesta Hotel, New Orleans, Louisiana. **Sponsor:** American Psychiatric Association, Office of Education. **Contact:** Maria Gorricks at (202) 682-6145. **Approved for:** 14 hours of Category I Credit.

7-9, Selected Hot Topics in Procedures. Location: Ashman Court Hotel, Midland, Michigan. **Sponsor:** The National Procedures Institute. **Contact:** Jill Frost, 4909 Hedgewood Drive, Midland, MI

(continued on following page)

Continued from previous page

48640, 1-800-462-2492. **Approved for:** 22.5 hours of Category I Credit.

10-15, Emergencies in Medicine.

Location: The Yarrow, Park City, Utah. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours of Category I Credit.

10-15, 18th Annual Winter Psychiatry Conference: New Perspectives in Clinical Practice.

Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

12-16, Family Practice 1996 20th Annual Spring Review Course.

Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School, Department of Family Practice, Michigan Academy of Family Physicians. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

18-22, PET and SPECT Imaging in Cancer Diagnosis and Treatment.

Location: Ihilani Resort and Spa, Kapolei, Hawaii. **Sponsor:** Johns Hopkins Medical Institutions, Office of Continuing Medical Education. **Contact:** Program

Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-2959. **Approved for:** 17 hours of Category I Credit.

22, Applied Clinical Informatics Symposium Topic on Information Systems of Immediate Importance for the Practicing Clinician.

Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School, Department of Family Practice, Michigan Academy of Family Physicians. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

22-23, Infant Psychiatry: Models of Clinical Intervention for Infants & Families: A Multi-disciplinary Approach.

Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

25-27, PET and SPECT Imaging in Cancer Diagnosis and Treatment.

Location: Thomas B. Turner Building, Baltimore, Maryland. **Sponsor:** Johns Hopkins Medical Institutions, Office of Continuing Medical Education. **Contact:** Program Coordinator, Johns Hopkins

Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-2959. **Approved for:** 18.5 hours of Category I Credit.

27-29, 17th Annual Clinical Sessions in Psychiatric Nursing: Maintaining Excellence in the Face of Change.

Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

28-29, Challenges and Changes in Obstetrics and Gynecology.

Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

30, Transvaginal Ultrasound Workshop.

Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

INTERNATIONAL COLLEGE OF SURGEONS - MICHIGAN DIVISION
ANNUAL SCIENTIFIC SESSION
FEBRUARY 7, 1996
8:00 a.m. - 4:00 p.m.
SINAI HOSPITAL, Zuckerman Auditorium, 6767 West Outer Drive, Detroit, MI

PROGRAM DIRECTORS

Eduardo Phillips, M.D., F.A.C.S., F.I.C.S., President, International College of Surgeons, Michigan Division, Chairman, Department of Surgery, Sinai Hospital, Detroit, MI, Clinical Assistant Professor of Surgery, Wayne State University, Detroit, MI
Andrew Saxe, M.D., F.A.C.S., F.I.C.S., Secretary/Treasurer, International College of Surgeons, Michigan Division, Section Chief, Endocrine Surgery, Program Director, Department of Surgery, Sinai Hospital, Detroit, MI, Clinical Assistant Professor of Surgery, University of Michigan, Ann Arbor, MI

GUEST SPEAKERS

J. Lee Sedwitz, M.D., F.A.C.S., F.I.C.S., Clinical Associate Professor of Surgery, East Carolina University School of Medicine,
LECTURE: The Belle Époque of Surgery, Life and Times of Theodor Billroth
Sofia Merajver, M.D., Ph.D., Assistant Professor, Department of Medicine, Director, High Risk Breast Cancer Clinic, University of Michigan, Ann Arbor, MI, **LECTURE:** Genetics of Breast Cancer - What the Surgeon Needs to Know
Edgar D. Staren, M.D., Ph.D., Associate Professor, Department of General Surgery, Assistant Dean for Clinical Curriculum, Rush Medical College, Chicago, IL, **LECTURE:** Ultrasonography for the General Surgeon
Andrew Saxe, M.D., F.A.C.S., F.I.C.S., **LECTURE:** What's New in Parathyroid Surgery
Jeremiah G. Turcotte, M.D., F.A.C.S., Professor of Surgery, Director, Organ Transplantation Center, Director, Liver Transplant Program, University of Michigan Medical Center, Ann Arbor, MI, **LECTURE:** Hepatic Surgery in the Era of Liver Transplantation
John B. Charles, Ph.D., Project Scientist, Human Life Sciences, NASA-Mir Program, Lyndon B. Johnson Space Center, Houston, TX,
LECTURE: Cardiovascular Aspects of Space Flight
S. David Nathanson, M.D., F.R.C.S., F.A.C.S., Professor of Surgery, Department of Surgery, Henry Ford Hospital, Detroit, MI, Case Western Reserve University, Cleveland, OH, **LECTURE:** Management of Sarcomas

OBJECTIVES: This program is designed to update knowledge in current issues in Surgery. It is open to physicians, residents and other interested health care professionals.

CREDIT HOURS: The International College of Surgeons - United States Section is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The International College of Surgeons - United States Section designates this continuing medical education activity for 6 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

REGISTRATION FEE: \$100 for physicians; \$50 for other health care professionals. There is no charge for residents or fellows of ICS to attend. Complimentary valet parking is available at the Zuckerman Auditorium Entrance off of West Outer Drive.

TO REGISTER OR FOR MORE INFORMATION, PLEASE CALL SHERI WALDMAN, SINAI HOSPITAL, 313-493-5279.

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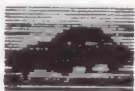
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POSITIONS OPEN

ASSISTANT/ASSOCIATE PROFESSOR - MSU/CHM, Department of Pediatrics and Human Development, is recruiting for a General Pediatrician, board certified or eligible. Responsibilities include patient care, teaching, and opportunities for research. One-half to full time positions available. Direct inquiries or send CV to Marsha Rappley, MD, Department of Pediatrics and Human Development, Michigan State University, B-240 Life Sciences, East Lansing, MI 48824.

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FAMILY PHYSICIANS sought for rural and midsize communities in Iowa, Minnesota, North Dakota, South Da-

kota and Wisconsin. Contact: VHA North Central, 3600 West 80th Street, Suite 550, Minneapolis, MN 55431. Call collect: 612-896-3492, FAX 612-896-3425. Ask for Jerry Hess.

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THORACIC/CARDIOVASCULAR SURGEON: BE/BC, to join 2 surgeon established private practice in mid-Michigan. Coronary artery bypass, valve repair experience preferred. Salary and benefits leading to partnership. Please respond with CV to: Lansing Heart & Lung Specialists, 2410 Woodlake Dr., Okemos, MI 48864.

WISCONSIN, MICHIGAN, IOWA - Major multi-specialty groups and a staff model HMO are seeking additional physicians specializing in Family Practice, Internal Medicine, Pediatrics, Hematology/Oncology, Nephrology and Occupational Medicine. Innovative, growing practices in safe, progressive communities. Choose from subur-

ban and metropolitan cities, college and resort towns, or rural destinations. Enjoy four distinct seasons and an abundance of recreation at pristine lakes and forests. For more information, call **Strelcheck & Associates** at (800) 243-4353.

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GENERAL SURGERY

Ohio and Wisconsin active searches for BC General Surgeons to join regional specialty program. Excellent support teams set in a collegial environment. Opportunity for research design and/or participation. Gastrointestinal surgery experience preferred. Elective major surgery. Limited evening and weekend call. Highly competitive compensation and benefits.

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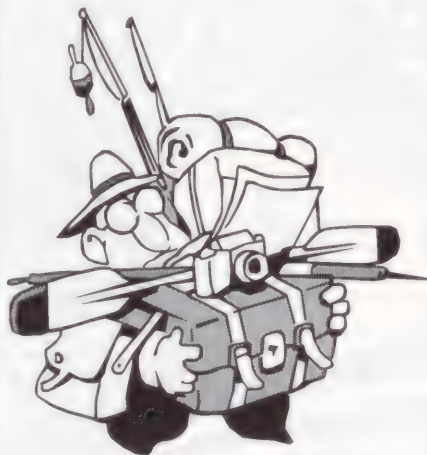


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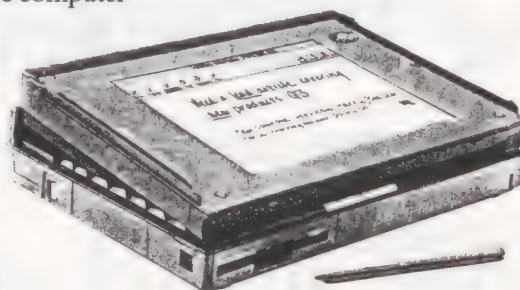
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Time Management

It will become more crucial as managed care grows

By B. David Wilson, MD

A vital piece of equipment in the physician's office of the not-too-distant future may be a stopwatch.

I don't mean this pejoratively. In no way am I suggesting that physicians do "splits" on their time spent with patients in an attempt to jam in more visits per hour.

I am only saying that physicians must take a very close look at how they are spending their time. How long does it take to see a patient presenting with a specific problem, or a type of visit? How long does it take to perform various procedures? How long does it take staff to do various tasks? The idea is time management. Knowing your costs. Efficiency without sacrificing quality care.

As managed care continues to creep into Michigan, I believe we all would be well advised to know how we spend our time. Managed care contracting is a difficult process, and as experience has shown in California and other states with high amounts of capitated health care, physicians need to know their costs in order to negotiate effectively. Frequently, payers will just make an offer and say "take it or leave it" and "you have 24 hours to decide." If you don't know your

costs, there is no way to make a truly informed decision quickly.

Time management and efficiency doesn't have to connote an office full of staff and physicians running around keeping all of the plates spinning. In fact, it can add to the serenity of a practice.

When you know that you can see a certain number of patients, when your staff knows what it can accomplish in a day, when you know that you are covering your costs and making a reasonable income, then you can relax into the prescribed flow.

Time management can add to the enjoyment of your personal life, as well. Keep track of your time spent on continuing medical education, figure in your vacation time, add up your hours spent in professional meetings, in community service, in healthful diversions. These are all part of your costs of doing business.

But they also play a part in your well-being, which is as equally vital to your practice and your patients as it is to yourself and your family. When you can figure in guilt-free time for relaxation and other pursuits, you can work more productively and efficiently when you are with patients. The shift to managed care seems to be inevitable. It will

bring with it changes that if not embraced and prepared for, might be the demise of many otherwise gifted physicians. For instance, the coming auto negotiations in Michigan may have a profound impact on the way health care is delivered in our state. We may find ourselves with thousands of auto workers in managed care plans, and if we do, we better be prepared to deal with it.

Preparation is the key. Do you have a sound business plan? What are your marginal costs? What are your average variable costs? What about your patient mix? Your quality measures and outcomes?

The delivery of health care is evolving, but physicians are still in the driver's seat. We need to stay aboard and try to steer health care in the right direction, rather than stamping on the brakes and swerving out of control, or just being towed along.

It will take determination and education, tenacity and tranquility and perhaps a stopwatch, but we will prevail in the new order of things. Our patients are counting on it. ■


Doctor Wilson is MSMS president.

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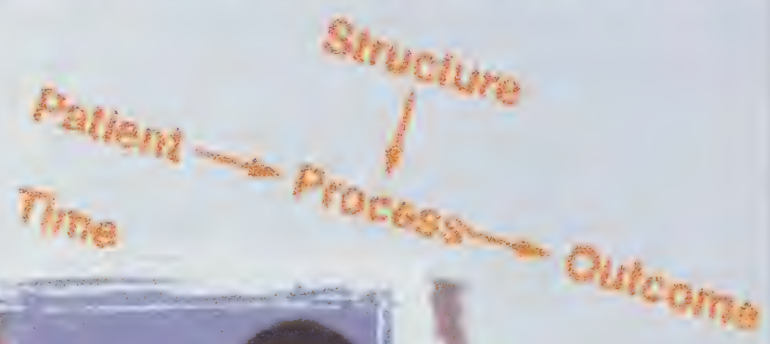
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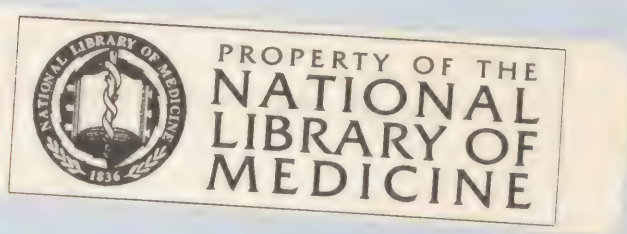
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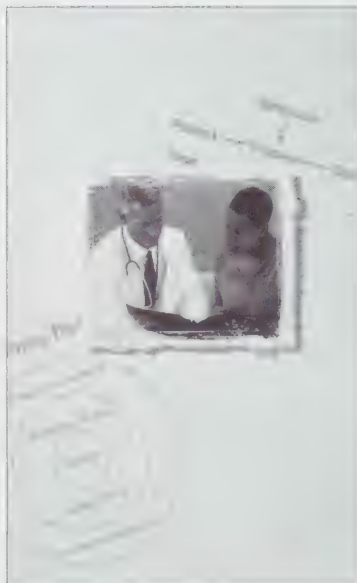
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COVER STORY



Outcomes Measurement 28

Changes in the environment of medicine have made outcomes measurement a research priority for the 1990s. What exactly is outcomes measurement and why are so many in the health care arena interested? These and other questions concerning outcomes measurement are the subject of this month's cover story.

Cover photo by: Roger Hill

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“We have a law in the state that says if you pray for your child, and fail to obtain medical care, and your child dies, you are not responsible for child abuse or neglect. Francis Horvath, MD, and I have been working for a number of years to repeal this law. Faith and religious beliefs support health care, and should be part of the treatment for any family that has faith. However, that doesn't mean that prayer should be used as a substitute for health care. Prayer and religion are an adjunct to medical care, but not a substitute for medical care.”

William B. Weil, Jr., MD, age 71
Pediatrician, East Lansing

“The real question is, ‘What role does medicine play for God?’ And the answer, of course, is ‘whatever role he wants us to.’” Since his consultants include Hammurabi, Hippocrates, Lister, Semmelweis and Osler, he can be counted on to be right. For more information, God's E-mail homepage address is <http://omnop.phys.edu>.”

James E. McGillicuddy, MD, age 55
General Surgeon, Lansing

“Ambrose Pare, a 15th Century French surgeon, said it best: ‘I care for him, God cured him.’”

Tom M. Johnson, MD
Internist, Kalamazoo

“To have the kind of in-depth knowledge that all physicians should have about their seriously ill patients, we have to understand the meaning of the illness in the context of the patient's life. In some patients it is going to be

through their belief system that the illness or disease has meaning to them; some may have other ways to say what the illness means

to them. Physicians should not be so afraid of offending patients that they fail to bring the subject up; nor should they assume that the patient shares the same belief system as the physician. A way to get around this, is to begin with a discussion about ‘meaning.’ If they volunteer that God or religion is how they determine what is meaningful to them, then we should be ready to explore this with them.”

Howard A. Brody, MD, age 46
Family Physician, East Lansing

“It depends on the patient. Some believe, some don't. Of those who believe, they invariably believe God has a hand in their cure. Most of my patients have some belief that God helps them in alleviating disease. I personally believe that the Almighty Power we believe in has a hand in care. Your inner sense of belief makes a difference in how you deal with disease.”

Busharat Ahmad, MD, age 64
Ophthalmologist, Monroe

“First, we can never discount God's role in the healing process. We've all seen miracles in our practices, things that can't be explained. Also, God guides us as physicians. I'm a Catholic, and go to mass every Sunday, and I know that I always ask for guidance. There have been many times that I've felt a helping hand there, and I think that's another way God plays a role.”

David M. Khovsky, MD, age 41
Anesthesiologist, Grand Rapids

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone.

We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490.

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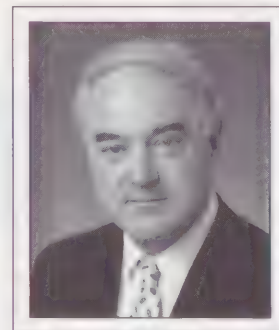
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Managed care and the Data Bank

By Richard D. Weber, MSMS Legal Counsel



Q: Must managed care entities report termination or rejection of physicians from their networks to the National Practitioner Data Bank?

A: As a general proposition, adverse actions based on economics are not reportable because they do not involve professional competence or conduct. Therefore, even if a managed care entity was deemed to be a "health care entity" under the law that created the Data Bank, there would generally be no reporting requirement for terminations based upon economic criteria.

If the action of the managed care entity is based upon competence or conduct and not economics, the answer becomes less clear. Under the Data Bank, reporting obligations are limited to "health care entities," which are entities that do two things: 1) provide health care services; and 2) engage in formal professional review activities.

If a managed care entity does both, it is considered a health care entity and has the obligation to report adverse actions that relate to a physician's competence or professional conduct. The question in this instance, therefore, is whether the entity meets the "provide health services" prong of the Data Bank test. Typically, such entities are formed to contract to provide health care, not to actually deliver health care directly. Assuming the network per-

forms peer review, it is unclear whether the contracting function is tantamount to providing health services. If the managed care entity simply serves as an intermediary between third-party payers and independent practitioners who provide the services, it probably would not qualify as a "health care entity," if the entity contracts with employers or payers and assigns member professionals to provide care to particular enrollees, it may look more like a "health care entity."

Despite requests for clarification on this issue, the US Department of Health and Human Services, which oversees the Data Bank, has provided no guidance. Legislation proposed in Congress (but not passed) would have altered the definition of "health care entity" to include entities that provide health services "directly or through contracts."

Q: Do managed care entities have the right to query the Data Bank about physicians?

A: The analysis would be the same relative to the reporting requirement discussed in the previous answer. If the managed care entity met the definition of "health care entity" under the Data Bank legislation, it would have the right to obtain this information. Again, the entity would have to establish the two-pronged test: provide health care services and engage in formal professional review activities.

Q: How can physicians determine whether a managed care entity qualifies as a "health care entity" to determine whether it has the right to query the Data Bank for information related to physicians and/or the obligation to report adverse actions?

A: The Data Bank does not have a procedure to verify whether an entity is a "health care entity" with the right to query or the obligation to report. The Data Bank relies on self-certification forms submitted by entities that assert that they are "health care entities," i.e., that they perform peer review and provide health services. There are currently several disputes pending where practitioners are challenging the validity of adverse action reports filed by entities that provide health services through contracts, but HHS has not taken action to resolve these disputes. ■

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to Betty McNerney, Editor of Publications, PO Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to bmcnerney@msms.org



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Mechanics of Medicine Need Changing

Residents to play key role

By Wendy L. Larson, MD

I've always felt that doctors shared a lot in common with auto mechanics. Both are inundated daily with nonspecific complaints, and must use considerable skill and expertise to identify where problems lie amidst a tangled web of parts. In addition, patients and consumers manage to take good health and trusty vehicles for granted on a daily basis. We count on our motors starting up each day to purr like Porsches as we speed through our busy schedules. It's always hardest to remember to maintain something when it isn't broken.

Certainly you have experienced that unsettling feeling when your car wouldn't start on a cold winter morning, when you were already late for work. Suddenly that lack of maintenance caught up with you. How could the wear and tear have accumulated without realizing it? Who will be able to give you a jump?

This is a strikingly similar fix to what medicine faces today. No one would argue that many aspects of health care in America could use an overhaul; however, to most of us struggling through residency, medicine appears to be alive and well. At

least there is no shortage of patients to keep us up at night. It is only when we occasionally come up for air, post call, and think about our futures, that the little squeak in that rear wheel is heard.

Now we know this in more familiar terms as 'health system reform,' but there are questions to be asked. Is it really happening? Who is in control? Where is it headed? What will happen to our patients? What will happen to graduate medical education? Right now, many of these decisions are being made by our representatives in Washington as they re-engineer Medicare. Unfortunately, neither legislators nor health insurers have been formally trained in the art of health care; or automobile maintenance. They

are looking for the quick fix, the paint job.

On a smaller scale, the real changes are happening in communities and academic centers across individual states, as in Michigan, where we rally for 'managed lives' to sustain our hospitals and practices. Our biggest challenge as physicians comes in adapting to the new managed care environment. Unfortunately, this can be akin to dealing with used car

salesmen. Our uneducated patients are more likely to answer to the loudest advertiser when choosing a health plan, unwillingly buying the used car with a deceptively nice paint job. Then we are left to put together the pieces to keep the system running in a breakdown. We can no longer scrap the parts and pay for a brand new engine.

Now more than ever, organized medicine and bureaucracy need input from the front lines of the battle for health system reform. That comes from residents. The future of medicine lies in our hands. Now is the time to be involved. Now is the time to care. All it takes is an idea, and the commitment to see it carried through.

As the leader of the Michigan State Medical Society Resident Physician Section and a member of the AMA-RPS Governing Council, I am working with colleagues on a state and national level to provide advocacy for residents in these tumultuous times. Our key issues this year include lobbying efforts to reduce cuts in Medicare funding for graduate medical education and expand it from other payers, legislative initiatives in workforce planning with educated reduction and reorganization of residency programs, and fostering of plans to enforce work hours reform and mandatory contracts for residents. On a local level we hope to increase membership and leadership in Michigan from all corners of the state. In order to impact change,



we must be informed about activities from hospital committees at our back door, to plotting in the political arena of Washington, DC. Integral to that will be communication with our members. We are sponsoring a speakers bureau and are working with MSMS staff to establish an RPS Home Page on MSMSNET where information about activities at the state and national level will be available in a convenient forum.

I encourage all of you to be involved, and take the challenge to help mold the future of medicine. There are many battles to fight. Armed with the proper perspective and motivation, we can make a difference. We are the mechanics truly responsible for the future of health care. It

is time to shift our focus to the goal, not the problem. Affordable, quality health care for our patients—and first-rate education, opportunity, and choice for those medical students who follow us.

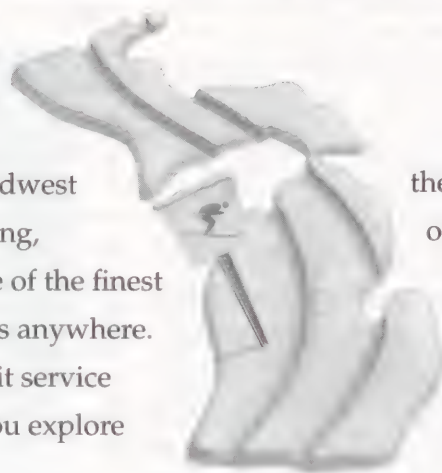
Let's be sure our health system remains a Porsche, and is not transformed into a VW! ■

Doctor Larson is chair of the MSMS Resident Physician Section.

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Stop Violence Everywhere

MSMS Alliance joins nationwide effort

By Jean Howard, MSMS Alliance President

"TC Man's Death Leads to Charge"

"Man Pleads Guilty in Attack on Wife, Daughter in Alden"

"Shootings Shock Grayling"

"Girlfriends say Fatal Shooting was an Accident"

"Random Slayings Leave Nation Fearful"



These headlines appeared in several Michigan newspapers recently within a period of approximately two days. The alleged abusers and murderers are not household names. Nor are the victims. So you won't see the trial on Court TV or highlights on the 11 o'clock news. But the violence that took their lives was as real as it was in the more celebrated cases in the media. Violence is among the leading causes of death in America and has replaced disease as the number one killer of children. Billions of dollars per year are attributable to violence-related deaths and injuries and add a tremendous burden to America's health care system.

In the hope of preventing violence-related tragedies, the American Medical Association Alliance has launched a program called SAVE: Stop America's Violence Everywhere. SAVE is an extension of the American Medical Association's

Campaign Against Family Violence and is intended to make an impact on violence wherever it exists — in homes, in schools, on the streets, in the media. We hope to focus nationwide attention on the need to address this devastating social problem by asking every Alliance in the country to emphasize violence prevention on one day of the year. The second Wednesday in October has been designated as the annual SAVE day.

The statistics on violence in this country are frightening. More than 4,000 women are killed each year as a result of domestic violence. More than 2,000 children die each year as a result of child abuse. There were over 13,000 homicides by handguns last year. Each day, over 10,000 children in this country go to school with a handgun. The bombing in Oklahoma last year heightened our awareness of the senseless violence that is pervading our nation. The recent trial of O.J. Simpson brought the domestic violence issue to the forefront. "Violence is the most profound, yet preventable, health epidemic of our time," says National SAVE Spokesperson and AMA Past President Robert E. McAfee, MD.

Over 60,000 members of the AMA-A around the country will take part in the effort to launch the national year-round program to

address root causes of family and media violence. Here in Michigan, Governor Engler's office will issue a proclamation declaring Wednesday, October 9, 1996 as SAVE day in order to help emphasize violence prevention in the communities in our state. Meanwhile, all county medical society alliance organizations are looking at how they can help promote SAVE day and the SAVE program in their communities. Many will be distributing the AMA-A's "I Can Choose" coloring book to young children. Genesee County has joined forces with the YWCA to promote a week without violence. Many fundraisers will be held throughout the state to raise money for women's shelters and safe houses. Oakland County will put posters in every high school asking students to sign the pledge against violence. Other counties are considering holding candlelight vigils, obtaining mayoral proclamations, having a "Walk Against Violence," or working with local PTA's to organize an effort to contact radio and TV stations regarding non-violent programming. Every county alliance in the state has plans to do something for the SAVE program. We know there is much to be done and we hope that by focusing attention on SAVE day we can make our country a safer place in which to live. Please join us.



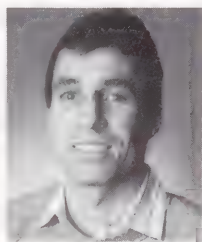
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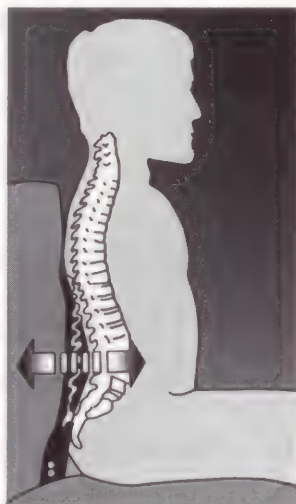


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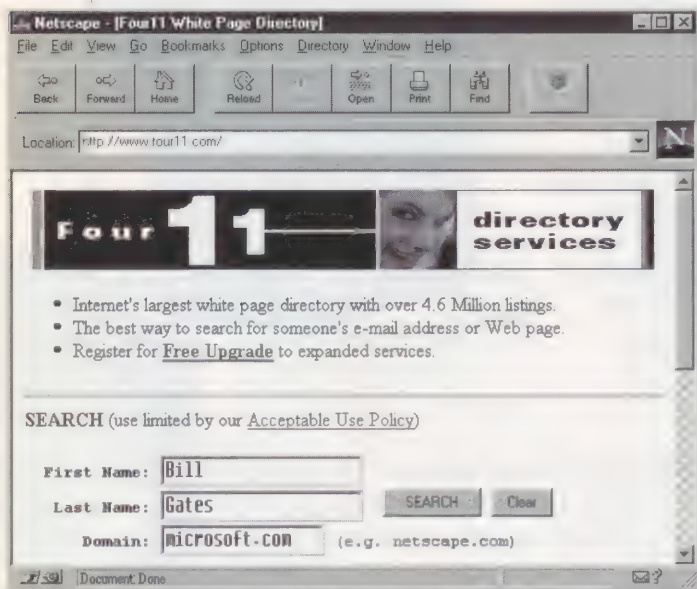
The answer used to be quite

simple: you couldn't. Fortunately, looking up someone's E-mail address is now possible by using a new E-mail searching tool cleverly named "Four

1 1". Users simply input a first name, last name, and/or domain name, and submit their search. Although the E-mail directory is currently limited, the database will likely grow. To help facilitate this growth, users may register their own E-mail addresses as a part of Four 1 1's registration process. You can find Four 1 1 at <http://www.four11.com/>

Physicians Guide to the Internet

The Physicians Guide to the Internet is a new World Wide Web site dedicated to "using the web's power to inform, entertain, and foster communication to help physicians enhance their personal and professional lives." Topics covered at <http://www.webcom.com/pgi/> include physician lifestyle information, clinical practice guidelines, tips for new physicians, ideas for postgraduate education, and other interesting and useful information you may want to check out. The Physicians Guide to the Internet also includes many clickable links to other Internet sites covering current medical news and other topics of interest to physicians.



Download Corner

Many Internet users are excited about the new developments being introduced on the World Wide Web. By this summer, almost every Web page will have interactive applications, live video and sound clips, and interfaces that will provide up-to-date news and weather. In order to use this next generation of Internet application, users need to download an Internet browser that is capable of running the newest applications. Netscape Communications Company, the industry leader in Web innovations, has just released Netscape Navigator 2.0

beta 5, which supports all the interactive Web functions currently under development. If you would like to preview some of the exciting new developments on the Web, you can download Netscape 2.0 from <http://home.netscape.com/comprod/mirror/>. After you install the software, you will be able to view sites with frames, Java applications, and HTML 4.0 enhancements. For a demonstration of these new features, jump to <http://proto.netscape.com/index.html> using Netscape 2.0.

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Michigan State Medical Society and the Perinatal Association of Michigan

present the

35th Annual Conference on Maternal and Perinatal Health

March 28, 1996, MSU Management Education Center, Troy



General Session

7:30 a.m. Registration and Continental Breakfast
8:15 a.m. Welcome
8:30 a.m. "Preconception Counseling"
9:30 a.m. Break

10:00 a.m. "Impact of Antenatal Steroids on Neonatal Outcome"
10:45 a.m. "New CDC Guidelines for Group B Strep Prevention"
11:30 a.m. Questions and Answers (all speakers)
Noon Adjourn to Luncheon Presentations

Concurrent Luncheon Presentations

- "3D Obstetric Ultrasound"
- "Fetal Therapy: New Horizons"
- "Experience With Liquid Ventilation"
- "The Capitated, Cost-Effective Sepsis Work-Up in the 1990's: Controversy and Caution"

- "Trauma in Pregnancy: What Does ATLS Have To Do With It Anyway!"
- "Recommendations from SIDS Task Force"

Concurrent Sessions in (A) Obstetrics and (B) Pediatrics

(A) Obstetrics

1:30 p.m. "Active Management of Labor"
2:00 p.m. "Midwifery Approach to Enhancement of Labor"
2:30 p.m. Questions and Answers
2:45 p.m. Break (return to general session)

(B) Pediatrics

1:30 p.m. "Post-Delivery Management of the Depressed Term Infant"
2:00 p.m. "Thrombocytopenia in the Newborn"
2:30 p.m. Questions and Answers
2:45 p.m. Break (return to general session)

General Session

3:00 p.m. "Shortened Hospital Stay of Mother and Baby: Implications on Readmission Rates of Newborn Infants"
3:30 p.m. "Creative Strategies for Safe Implementation"
Panel:
■ Munson Medical Center Maternity Prepared Stay Program
■ Partnership in Pregnancy and Parenting at Henry Ford Health System

- William Beaumont Hospital Program
- "Family Roads" at Hutzel Hospital
- 4:30 p.m. Interactive Discussion
- 5:00 p.m. Adjournment

Advance Registration for Conference on Maternal and Perinatal Health, March 28, 1996

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- _____ "Fetal Therapy: New Horizons"
- _____ "Experience with Liquid Ventilation"
- _____ "The Capitated, Cost-Effective Sepsis Work-Up in the 1990's: Controversy and Caution"
- _____ "Trauma in Pregnancy: What Does ATLS Have To Do With It Anyway!"
- _____ "Recommendations from SIDS Task Force"

Afternoon Concurrent Sessions: ☐ Obstetrics or ☐ Pediatrics

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Patient Advocate Forms

We should encourage patients to use them

By Cheryl Farmer, MD

It's been nearly five years since Michigan enacted a Durable Power of Attorney for Health Care law. The law enables patients to appoint a durable power of attorney and state in writing on a Designation of Patient Advocate Form their wishes regarding their medical treatment should they become incapacitated. It's a well designed document. It's unfortunate so few patients are using it!

Shortly after the DPA became available, the two internists with whom I practice and I decided to discuss the issue of DPA with each of our patients at the time of their complete physical exam. Over the past four years we have distributed approximately 3,600 DPA forms. We estimate only two to three dozen forms have been returned!

"Because responsibilities to patients do not end when the patient becomes incompetent, we owe it to our patients and to ourselves to continue to look for ways to clarify and record patients' wishes."

should give some thought to the issue. We then give them a copy of the DPA booklet and invite them to look it over, complete the form, and return a copy to the office. The patient is further

asked to provide a copy of the form to the person they chose as their patient advocate and to keep the original with their important papers. The rate of return of these forms is so low that every one returned is remarked upon!

Interestingly, when older patients return for their annual physical exam a year later and are again asked if they are familiar with the DPA, they generally

respond in the negative. Why this is, we don't know. It is also interesting to note that the return rate following a second discussion of DPA isn't any better.

Difficult cases

In Michigan, there is currently no statute that specifies what is to be done on behalf of a patient who becomes incompetent and has not executed a DPA. These are the difficult cases that frequently wind up in court when the remaining family members are not in full agreement. These also are the cases that wind up in hospital ethics committee discussions. They pose the most risk for the physician who has known the patient for many years, understands what the patient would have wanted, wants to do the right thing for the patient, and finds the family to be in conflict regarding the physician's recommendations. If the DPA is such a good tool, what can be done to increase the percentage of the population which has completed one? Furthermore, what should be done to assure autonomy for those patients who fail to complete a DPA?

Thinking about mental incompetence appears to be as difficult as thinking about death. The patients who are likely to postpone signing a DPA are the same patients who have failed to execute a will. Mental incompetence and death are difficult issues for all of us.

During recent conversations with colleagues on the Michigan State Medical Society Bioethics

Committee, I heard a story about a workshop on the Michigan DPA for physicians and spouses. It was reported that approximately 100 DPA forms were handed out during the discussion. People were encouraged to act as witnesses for one another. At the end of the session, the DPA forms were to be completed. Only one of the 100 had been filled out! Is it any wonder that discussions of code status are so difficult with sick patients, when discussion of DPA is so difficult with well patients, not to mention well physicians and their spouses!

We would like to encourage all colleagues in primary care medicine to begin dialogue about the DPA with their patients. The more this issue is discussed, the less frightening it will be. However, because of the extremely low rate of return of DPA forms in our four-year experience, I have begun to ask patients at the time of discussion to verbalize who they might choose as to their advocate and to note it in their chart. This provides additional guidance for the physician, and documentation for the family, in the event that something untoward should happen before the DPA is executed.

Dialogue needed

I believe it would be helpful for physicians as a group to begin a dialogue with legislators regarding the need for a law that addresses the issue of choosing surrogate decision makers for patients who become incompetent without a

DPA. There is a precedent for this in some states where lists have been formalized to guide the physician. For example, the law might state that the surrogate decision maker shall be the spouse unless the couple is separated, followed by the first born child if older than 21 years, followed by the father if still living, followed by the mother if still living, etc. In the absence of such guidance, these cases all too frequently can wind up in court due to disagreement among family members about what should be done and by whom.

Because responsibilities to patients do not end when the patient becomes incompetent, we owe it to our patients and to ourselves to continue to look for ways to clarify and record patients' wishes. Based on experiences in my practice, the simple distribution of DPA documents to patients in times of good health is nowhere near sufficient.

Doctor Farmer is an Ann Arbor internist and member of the MSMS Committee on Bioethics.

DPA forms, brochures available from MSMS

Designation of Patient Advocate Forms and accompanying brochures can be ordered in quantity through "Patient Advocate." Price is 40 cents for the pair when ordering 100 or more. Under 100, the price is 45 cents. Minimum order is 50. The Designation Form is an eight-page booklet. The document is designed to be a "user friendly" form, particularly for older

patients. The short patient brochure accompanying each form covers more detailed information about the new DPA law.

To order, write: "Patient Advocate," P.O. Box 950, East Lansing, MI 48826-0950, or fax: (517) 336-5797, Attn. Bridgett Benton, or E-mail bbenton@msms.org



"We would like to encourage all colleagues in primary care medicine to begin dialogue about the DPA with their patients."

Business Strategy

It's an essential tool for group practices

By Kenneth M. Hekman, MBA

Each era seems to have its business buzzwords. One of the more widely used adjectives recently has been "strategic." Business plans are now strategic business plans. Marketing objectives are now outlined in strategic marketing plans. Strategic management sounds distinguished from classical management. So what changed? Are these new terms just updated names for old concepts or is a strategy a unique business tool for the nineties?

What is a business strategy?

One of the essential concepts in understanding business strategy is the idea that medical practices function in a competitive environment. In the absence of alternatives, patients don't have the benefit of a choice for their medical care and physicians are not pressed to be responsive to patient's needs beyond their own convenience. The absence of alternatives is a circumstance that is becoming very rare in the United States and Canada, although there are still rural communities where medical practices function as virtual monopolies. Even in those rare situations, however, patients still have choices for medical services if they are mobile. For the vast majority of medical practices, competition has become a way of life.

Business strategy determines how a medical practice will compete and how it will position itself among its competitors. The concepts of a strategy can come together in the form of a written statement, but they are rarely fully understood and communicated by mere words. Business strategy combines the purposes, values and dreams of the medical practice leaders and becomes its unique identity. As such, the strategy is seen in the daily decisions made by each employee in the practice and is felt in the quality of workmanship. A newcomer can sense part of the business strategy of a practice by observing the activities that are given priority and

importance, by hearing the sounds of people serving each other and by interpreting the level of unified commitment and enthusiasm for the purposes of the practice. The independent observer can come away with an understanding of what makes the practice uniquely successful compared to the competition. He can know why patients prefer seeing the doctors at that practice rather than seeking

alternatives.

In a sense every practice has a strategy, whether it is acknowledged or not. If a practice has more patients than it has capacity to manage appropriately, its strategy can be interpreted as being focused on high volume rather than on timely patient service. If a medical group has a reputation for long waiting periods at appointment times, its values can be understood to be more oriented toward physician convenience than patient convenience. Those strategies may not be the most effective in a competitive environment, but they're reflections of the group's values. As competition increases and patients begin to prefer medical services that more closely meet their needs, those values will come under closer scrutiny out of economic necessity.

It is wise, therefore, to assess the business strategy before it becomes an imperative. By examining the values expressed in the actions and policies of the medical practice, managers and physicians may discover incongruities previously undetected. An evaluation of the business strategy may also reveal opportunities for greater service that can help to differentiate the practice from its competitors.

Steps for developing a strategy

Since a business strategy is a reflection of human values, a good place to begin is to

"Look for unique strengths to distinguish the medical practice."

"Medical practices, like all businesses, need a strategy."

articulate the values of the group's leadership. Physicians should ask themselves what they enjoy best about the practice of medicine. For example, "If I could choose an ideal medical practice setting, it would be..." Complete the sentence with attention to the kinds of patients you would like to take care of, the type of medical support you would prefer and the lifestyle you would select.

The next step is to examine the unique characteristics of the practice environment, paying attention to opportunities for a competitive advantage that might match well with one or more of the items on the list of human assets. This may involve a formal research project to determine the perspectives of current and former patients or it might consist of a literature search, a visit with the local Chamber of Commerce executive, a tour of the neighborhood and a handful of informal conversations with friends and colleagues designed to uncover fresh ideas about how to make the practice unique. The search for ideas can be unlimited, and the power of the ideas is contained only by the energy and skill of the leadership required to evaluate them for their ability to fit into a successful business strategy.

The third logical step is to match the list of human values and assets of the group practice with the list of opportunities for a competitive advantage. If there are not any obvious matches, look for less obvious ones. An orthopedic physician with a strong interest in sports medicine, for example, might find stiff competition for a position as the team physician for the local high school, but find interest at a progressive manufacturer to develop a fitness program for employees. A family doctor with certification in geriatrics may find the local nursing home satisfied with their medical director, but eager for new perspectives on their utilization review committee. Each opportunity may not be a direct fit, but may be an indirect path to a satisfying and successful long-term relationship.

The matching process should examine the values of the marketplace as thoroughly as the specific options for new services. Let patients, past and present, tell you how they expect to be treated. Listen to the characteristics they value in other services they receive, whether they be medical services or other human enterprises. Let them express how they measure your success, and

compare that information to your own standards for success.

Marking progress

At this point, the business strategy is fairly well developed as a concept and it is ready to serve as a basis for decisions. The matching process will create an agenda for management that may include correcting an operational condition that is not in line with the group's values, or developing a new service the community needs and the group can provide. The business strategy continues to emerge as new opportunities present

"Strategies need to reflect the values of the physician-owners."



themselves and are evaluated in light of the corporate values. It will grow as there are competitive challenges to established services and methods. It will take on significance as the group periodically reviews its list of services and values in an effort to maintain a competitive advantage.

Developing a business strategy is more than borrowing a buzzword. It is an essential tool, designed to help a practice understand itself and its patients and use that information to blend patients needs and the human assets of the medical practice. ■

The author is president of Hekman & Associates, Inc.

"Monitor your success in achieving your strategy."

Psychological trauma

Experience intensifies physician's compassion for patients

By Milton F. Simmons, MD

About 10 months ago, I underwent a "redo" inguinal herniorrhaphy. The original herniorrhaphy was done while I was in the Army in 1952. Despite the "MASH"-like surroundings, the experience was made physically and emotionally comfortable by a wonderful nurse anesthetist, who took charge of me after the surgeons spinal. First, she demonstrated to my visual sense where my block extended to; thus I knew I would not feel anything.

"I have always treated my patients in a humanistic, caring, compassionate and communicative manner. Now I have intensified my efforts..."

She then gave me my pre-op injection, probably Demerol and Atropine, and finally, she sat beside me so that I could see her, and we talked the entire hour that it took for the surgery. It was the best 60 minutes I ever spent in the Army.

Methodology is supposed to improve in 43 years, but for me it did not. I found myself, in spite of the theoretically ample IV, pre op medications, I was only semi-sedated for 10 minutes. At the time of my entry into the O.R., I was completely alert.

The spinal was administered beautifully, but the psychological trauma began. For the next 15 minutes, I languished in exquisitely, brutal isolation. All I could see was the ceiling and not a word or sound came forth from anyone. There was probably more noise in the hospital morgue than in that O.R. I forced myself to remain calm by biting my lip for control and counting out time in minutes, my only mental stimulation. What the nurse anesthetist could observe was a good

patient externally. Actually, internally, I was becoming a terrible patient. Mercifully, by the 15th minute, Propofol was issued via the IV route; I did not request, want or know that this type of anesthesia was going to be used. Total immersion anesthesia frightened me, that is why I chose the spinal.

My surgery repair was excellent. I went back to work in three weeks. By the fifth week, I

developed depression, or a form of post traumatic stress syndrome, waking up in bed at night with flashbacks of being on the O.R. table. It took about seven months for me to get control of myself, as severe anger and loss of self esteem plagued me continually. Naturally, I talked to professional colleagues, but the turning point occurred when I wrote a more detailed paper than what I have described here. The writing of the paper actually poured out of me in a six-hour period. It was cathartic for me, and feedback for the anesthesia department.

This experience has made me a better physician. I have always treated my patients in a humanistic, caring, compassionate and communicative manner. Now I have intensified my efforts especially in the psychological overlay, which may be the cause of the physical problem. My paper has become a new tool of my practice. I have found by allowing my stressed and depressed patients to read my manuscript, a therapeutic level of understanding can occur with positive results. I feel that I am treating the whole patient now, and probably reinforcing my own cure.

Doctor Simmons is Warren family physician.

Have a story you would like to share? Submit your thoughts or experiences regarding physician well-being to: Michigan Medicine, P. O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490, or E-mail them to bmcnerney@msms.org

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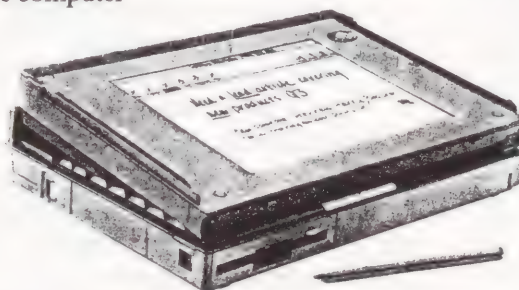
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Evaluating Managed Care Contracts

By Dean G. Smith, PhD

The specific financial terms of a managed care contract are critical to the ultimate decision to accept, reject or modify the contract. Evaluating the financial implications of contracts requires information on risks and some basic analytical tools of financial risk analysis. Three items of particular importance in the financial evaluation include: health plan benefit design, the number of covered lives and the characteristics of those covered lives.

Benefits

A fairly typical set of health benefits in a managed care plan and the calculations that lead to overall plan costs are shown in the accompanying table. The per member per month primary care physician capitation is \$24.13, absent any incentive payments, withholding for risk pools or administrative fees. Services covered under the capitation are all routine medical office services including routine physicals, well-baby visits, consultations, and in-office surgery. At the listed levels of utilization of professional services and hospital services, there is an expected incentive payment to primary care physicians for \$2.36 per member per month, paid annually. If referrals exceed 950 or if medical/surgical hospital days exceed 250, the incentive payment is reduced.

Obviously, a consideration of the appropriateness of this set of benefits and the corresponding use rates and costs per service is dependent upon the administrative treatment of each line of benefits, usual practice patterns and costs in a particular geographic area and the characteristics of the population that will be enrolled. Take for example the administrative treatment of radiology professional fees. The base assumptions are that there will be 991 claims paid

per 1,000 members at an average rate of \$62.70 per claim. What are usual use rates? If usual use rates are 1,120 per 1,000 members, does this assumption imply some type of administrative utilization management program for radiology, or some type of incentive program tied to primary care physician incentive payments? How are radiology professional fees paid? Are radiologists paid

fee-for-service, or is there a capitation at \$5.18 per member per month? If radiologists are capitated, how much effort must other physicians exert to obtain radiology services? Examination of current use rates and administrative treatment of all services is required to render an opinion on the appropriateness of a set of benefits. For some contracts, primary care physicians may have to spend more time examining benefits for radiology and other services than time examining their own rates.

A two-edged sword

Appropriateness of benefits is a two-edged sword under managed care contracting. The comprehensiveness of benefit packages and ease of access to services will be evaluated by purchasers and consumers for value and will affect plan enrollment and the characteristics of observed enrollment. Plans offering better value will have greater enrollment. Plans offering more comprehensive services and easier access to services without adequate premium differences may have the potential for adverse selection. That is, high benefit plans at high prices may be selected only by those persons expecting to use high levels of services. A plan with high levels of benefits and a primary care capitation rate of \$35 per member per month may be viewed by some physicians as being more attractive than a lower benefit plan with a capitation rate of \$25 per member per

"Evaluation of the 'success' of a contract should be tempered by the level of enrollment."

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month. However, if primary care costs are \$34 and \$20, per member per month, respectively, in these two plans, the lower benefit plan may be preferred.

Enrollment

Among the most frequently asked questions in capitated arrangements is the number of covered lives required for acceptable risk-sharing. The answer most frequently given is that it is hard to tell. Since there are substantial variances in the distributions of costs and use rates even within small geographic areas, and since the characteristics of enrollment affect these distributions, exact answers are difficult to give. As a rough guide, some reports have suggested that primary care physicians should have 500 persons before accepting full risk. For referral service panels, the numbers are much larger. Hospital capitation panels generally should have 5,000 persons, although most hospitals can bear risk more readily than individual physicians.

Most managed care contracts include a tiered structure relating level of enrollment to degree of risk-sharing. At enrollment of fewer than 100 persons, payment may be fee-for-service. But as enrollment increases, more risk is transferred to the physician. Evaluation of the "success" of a contract should be tempered by the level of enrollment. At fewer than 100 persons, a physician may gain knowledge of the administrative ease or burden associated with contracting, but will have almost no actuarially credible data on use and costs.

Underwriting

The characteristics of populations under consideration for capitated systems are inextricably tied to the capitation rate required for an acceptable contract. It is the characteristics of enrollment and their relationships with health care providers that affect the predictability of costs, use rates, pricing strategies, and operational capabilities of a health plan. Defining an empiri-

cally reasonable capitation rate is a task for health plan actuaries and underwriters. Actuaries examine underlying populations and statistics to determine reasonable rates. Underwriters examine potential firms and consumers to assure a match between plan enrollment and the underlying populations that determine rates. If underwriters are able to set policies that result in lower than average users of care, the plan may be more

(continued on following page)

Example Capitation Rates: 1995

	Utilization per 1,000	Cost Service	Cost PMPM
Primary Care Services			
Primary Care Capitation (A)	12,000	24.13	24.13
Physician incentive payments	12,000	2.36	2.36
			26.49
Referral Professional Services			
Specialist visits	744	74.46	4.62
Inpatient hospital visits	499	176.20	7.33
Emergency room visits	553	86.77	3.54
Surgery	207	147.09	2.54
Radiology professional fee	991	62.70	5.18
Lab professional fee	4,040	10.27	3.46
Anesthesia	133	239.06	2.65
Mental health/substance (B)	499	113.47	3.68
Miscellaneous	882	69.43	4.66
			37.64
Facility Services			
Inpatient hospital med/surgery	169	1,021.74	14.39
Inpatient maternity	29	1,427.11	3.45
Inpatient ICU/CCU	43	1,736.97	6.22
Outpatient	576	221.76	10.64
Outpatient lab, radiology	707	37.78	2.23
All other facility services	90	740.19	5.55
			42.48
Other services			
Vision	275	82.01	1.88
Medical equipment	1,701	7.42	1.05
Prescription drugs (C)	5,041	30.58	30.58
			33.51
TOTAL COST PMPM			140.13

Notes: Many of these services require copayments. Of particular note are:

(A) \$5 per office visit for use of primary care physician services. The primary care capitation is based on the assumption of 2,911 primary care visits per year per 1,000 members.

(B) \$25 per visit for mental health/substance abuse services.

(C) \$5 per prescription.

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profitable per enrollee, but have lower than expected enrollment. If underwriters set policies that result in higher than average users of care, enrollment may be higher than expected, but at a lower profit per enrollee. Finding the balance between enrollment and profit is a key requirement of success in underwriting.

Underwriting as a concept is often criticized, particularly in the area of explicit rejection of individuals or groups for insurance coverage based upon pre-existing health conditions. At many times there has been legislation proposed to curb such actions. However, careful underwriting involves not only accepting or rejecting potential enrollees, but establishing benefit plans that meet the needs of a cross-section of the population and policies and procedures that attract a cross-section of enrollment.

The practice of underwriting is common in the insurance industry, but somewhat less active in many managed care plans. Since many HMOs

have experienced favorable selection in recent years (enrolling healthier than expected persons), underwriting has been somewhat of a lesser issue in managed care. However, as managed care grows, relying upon favorable selection becomes more difficult. Of course, there are ethical considerations that must be brought to bear in the discussion of underwriting, but so too must the business considerations. As a matter of policy, the structure of underwriting must be determined by managers and participants in managed care contracting. Deciding not to have a strict underwriting structure after weighing pros and cons is a reasonable outcome. Ignoring underwriting structure because of fear of ethical conflicts is an irresponsible outcome. ■

Doctor Smith is an MSMS Physician Organization consultant and an associate professor, Department of Health Services, Management & Policy, University of Michigan School of Public Health.

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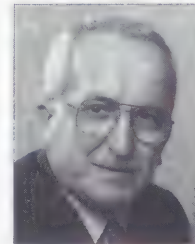
Medicare:

Number 2



This is the second in a series of monthly articles that will examine Medicare. In the months ahead, we will detail the practical effects on beneficiaries (and prospective beneficiaries) of changes to Medicare now under consideration by Congress and the President. This piece describes current Medicare benefits, beneficiary premiums and copayments, and their lesser known features. It also speculates on how the profound changes still under discussion may change these aspects of Medicare.

—Earl G. Moehn, MD, Chair
MSMS Group Insurance Trust



The Basics of Medicare: What you may not know

Everyone knows that Medicare is a program that provides health care to seniors and persons with disabilities. Few approaching age 65, understand the intricacies of the program. Medicare covers many services, but it does not cover others. Deductibles and copayments on most services have seniors reaching for wallets more frequently than they thought they would. The typical Medicare beneficiary spends more than \$3,000 a year in out-of-pocket expenses for health care, even with Medicare supplemental insurance to fill in the gaps.

Medicare Hospital Insurance (Part A)

Part A encompasses inpatient hospital care, skilled nursing facility (SNF) care following a hospital stay, home health care, and hospice care. Most beneficiaries pay no premium for Part A, but hospital stay could create a financial burden. If you are admitted to a hospital for 60 days or fewer, you must pay a deductible of \$716. Should you remain in the hospital for 61-90 days, you must then pay \$179 per day; the payment doubles for days 91-150. After 150 days, Medicare pays nothing for hospital care.

In certain circumstances, a beneficiary may have to pay the inpatient hospital deductible more than once a year. Medicare requires you to pay this deductible for each benefit period. A benefit period starts the first time you get inpatient hospital care under Medicare; it ends when you have been out of the hospital or skilled nursing or rehabilitation facility for 60 days in a row. It is conceivable, then, that you could be hospitalized for one condition and then rehospitalized for that or another malady two months later. Should that happen, you would begin a new benefit period and pay the \$716 deductible again.

Contrary to public perception, Medicare does not pay for much long-term care. Part A's coverage of institutional long-term care is limited to skilled nursing facility (SNF) care. Medicare does not cover custodial care (help in walking, eating, bathing, dressing that can be provided by people without professional training) except as part of care in an SNF. Also, Medicare helps pay for SNF care only when (a) your condition requires daily skilled nursing or rehabilitation services, (b) you have been in the hospital at least three days in a row, and (c) your care in the SNF is for a condition that was treated in the hospital. Once you have succeeded in qualifying for SNF care, Medicare pays the full amount of your care for only 20 days. Should you need 21-100 days of care, you are

(continued on following page)

Critical Analysis



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responsible for \$89.50 each day; beyond 100 days, Medicare covers nothing. Given these restrictions, it is no surprise that Medicaid finances the majority of the country's long-term care bill.

Medicare's coverage for home health and hospice care is more generous. Home health services include part-time or intermittent (but not 24-hour-a-day) skilled nursing care and home health aide services in the home; physical, occupational, and speech therapy; medical supplies (but not prescription drugs), and durable medical equipment (DME). The beneficiary is required to pay only 20 percent of DME expenses. Hospice, which can be home or inpatient care, covers doctor and nursing services every day, drugs, counseling, and other services that relieve pain and manage symptoms for beneficiaries with terminal illness.

Medicare Medical Insurance (Part B)

Part B covers doctors' services inside and outside the hospital, outpatient hospital care, diagnostic tests, DME, ambulance services, and other health services and supplies not covered by Part A. Part B does not cover most routine physical examinations, most routine foot and dental care, examinations for prescribing and fitting eyeglasses or hearing aids, the hearing aids themselves (but it does not cover eyeglasses), cosmetic surgery, and significantly, most prescription drugs.

The monthly premium for Part B in 1996 is \$42.50, down from \$46.10 in 1995. This could very well change when Congress and the White House reach agreement on Medicare reform in balancing the federal budget. Many anticipate that Part B premiums will increase for all Medicare eligibles, almost doubling in the next seven years. High-income Medicare beneficiaries—high income is not yet defined—are likely to pay even higher premiums, including one for Part A.

Most people unfamiliar with Medicare do not realize that under Part B, in addition to the annual deductible of \$100, beneficiaries must usually pay 20 percent of their health care bills. The only major exceptions are lab services (no copay) and outpatient mental health services (50 percent copay). If doctors participate in Medicare, they agree to accept the amount approved by Medicare as total payment for services delivered. In such cases, beneficiaries pay 20 percent of the approved amount. Doctors who do not participate in Medicare may still see Medicare patients. The patient is then responsible for 20 percent of the Medicare-approved amount plus any doctors' charges up to 15 percent over that amount.

Medicare Managed Care Plans

The debate on Medicare reform often masks common ground. Republicans and Democrats alike believe that increasing Medicare enrollment in managed care plans is a necessary step toward controlling program costs. Currently, most Medicare beneficiaries can enroll in managed care plans, most of which are HMOs. In 1995, estimates put managed care enrollment at 2.5 million beneficiaries, roughly seven percent of the Medicare population. There is little doubt that these numbers will grow once reforms are enacted.

In general, HMOs cannot screen applicants to decide if they are healthy or delay coverage for pre-existing conditions. To be eligible for enrollment in an HMO, a beneficiary must live in the plan's service area. Also, he or she cannot be receiving care in a Medicare-certified hospice and cannot have permanent kidney failure.

HMOs serving Medicare beneficiaries may offer benefits not covered by Medicare for little or no additional cost. These may include preventive care, prescription drugs, dental care, and hearing aids. In many cases, HMO coverage is comprehensive enough that less costly Medigap insurance is required.

How Might This All Change?

The irony of the reforms under discussion in the nation's capital is that they do not appear to change Medicare much. Benefits will likely continue to remain unchanged, and beneficiaries enrolling in HMOs may even see their benefits expand. There has been little talk of increasing copayments and deductibles, perhaps because many beneficiaries already consider them substantial. Premiums will probably go up, especially for higher income eligibles. It is possible, too, that people will not be eligible for the program until they reach age 66 or 67 instead of the current 65.

What will inevitably change is how these benefits will be delivered to Medicare beneficiaries. New systems for reimbursing providers and health plans are under consideration that could profoundly alter how doctors, hospitals, and others care for you. The implications of these changes, summarized in this series' first article and still being debated, will be examined in the months ahead.

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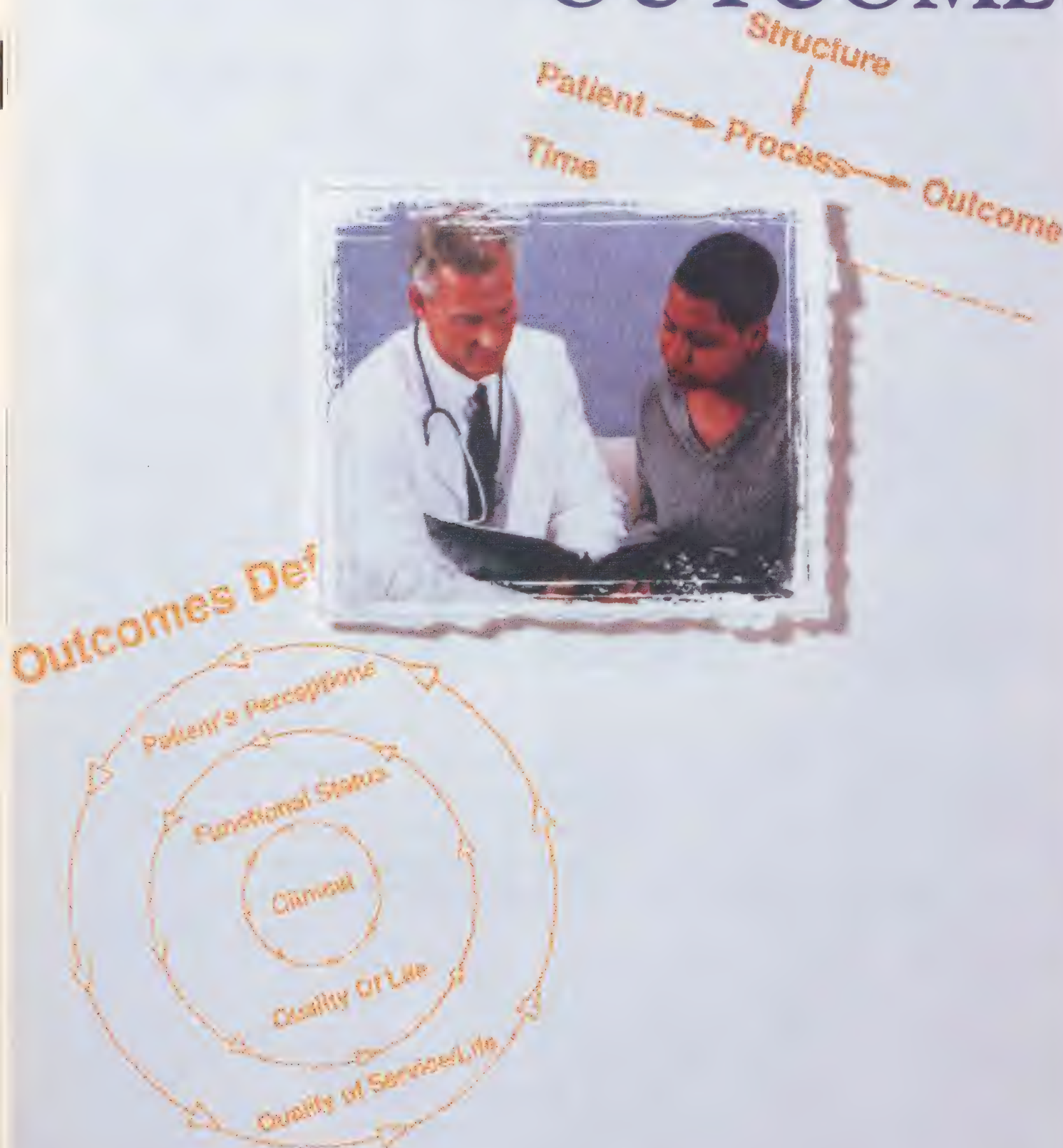


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OUTCOMES MEASUREMENT

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Changes in the environment of medicine have made the development of outcomes measurement a research priority for the 1990s. Medical outcomes and quality assessment have captured the attention of third party payers, business coalitions, sponsors of reform proposals and other groups interested in health care delivery.

Because of the timeliness and importance of this topic, the Michigan State Medical Society convened the first major conference on outcomes measurement in Michigan late last year. As keynote speaker John E. Wennberg, MD, MPH, director, Center for Evaluative Clinical Sciences, Dartmouth Medical School, told conference participants, "Ubiquitous, confusing, arcane, and technical are words which often come to mind when thinking about outcomes measurement." What exactly is outcomes measurement and why are so many in the health care arena interested in it? The following cover story attempts to answer these and other questions concerning outcomes measurement.

Why Measure Outcomes?

Measurement is the core of outcomes research

By Julie Lester

"There are substantial differences in the risks and benefits associated with different treatment choices; in order to make the right decision, patients must be fully informed and empowered to base their decision on their own values and expectations."

— John E. Wennberg, MD, MPH

Measuring patient outcomes allows us to predict resource consumption, identify patient expectations and help them choose among treatment options, and determine targets for quality improvement. It translates what happens in rigidly structured and controlled clinical trials to the unstructured, less controllable world of clinical practice. It allows physicians to measure the impact of treatment on patient health, and then make changes or improvements based on what has been learned.

An outcome can be defined in different ways, depending on whose perspective it is. To a clinician, the relevant outcomes are signs, symptoms, test results and complications. Patients define outcomes in terms of quality of life and well-being. Employers are concerned with work days lost, worker productivity, and cost. To society, the ultimate outcome is how much health is produced for how many people at what price.

Data as a tool

The core of outcomes research is measurement: data that document the patient's functional status and quality of life over time and changes in the patient's clinical condition. Unlike traditional medical research, outcomes measurement is an ongoing observational study, which records information using terms relevant to patients and physicians. As physicians prepare to document quality for insurers and employers, their definitions will need to be addressed as well. Ultimately, these measurement systems will need to be practical in ordinary practice settings.

An outcomes measurement system requires the following components:

1) A plan defining the question of interest—It may be a condition for which there are several treatment options, or a new technology or procedure that has not yet been proven to have better results than the older, less expensive treatment.

2) Data variables of interest to physicians—If physicians agree that the data being collected are the most important, the quality and completeness of the data collection process increase.

3) Standardized data collection protocols—Whether collected on paper forms or directly entered into a computer system, the data must be consistently recorded for the end

analysis to be meaningful.

4) Technology for data input and analysis—

5) Physician leadership, buy-in, and involvement—Practicing physicians need to participate in the question definition, project design, and resulting analysis. Their input and commitment not only ensures a better study, but also ensures that the knowledge gained will be accepted as valid and will be applied in their clinical practice.

Which data to use

Good outcomes studies require good data, an issue that should be important not only to physicians but also to those who want some measurement of quality, such as employers and business coalitions. The most accessible of data sources, claims data, seems obvious to others because it is already assembled. Those not familiar with claims data, however, may not realize that it is a better measurement of how third party payers pay for services than it is a measurement of what actually happened to the patient.

Another source of data are sometimes called "process measures," such as those reported by the National Committee on Quality Assurance (NCQA). Often termed "report cards," these measures quantify how frequently things occur, such as immunization rates, prenatal visits, re-operations, or emergency room visits. Although these indicators have value, they do not assess

how the processes being measured impact overall health. It is a measurement of how well the system is doing things, but begs the question of whether those are the right things to be doing to achieve our goals.

A more comprehensive approach to outcomes measurement allows the physician to assess the functional health status of the patient, determine patient satisfaction with the delivery of care, assess clinical indicators for particular condition, and measure what resources were used to achieve that care. The first component, the patient's functional status, is critical and should not be overlooked, because the bottom line is whether the patient's quality of life improves in some meaningful way.

How do we ensure proper use of the data?

Employers have been pushing for lower costs for almost two decades and, in fact, premiums for managed care plans are moderating in many markets. But all of this price competition is also causing employers to wonder whether they are still getting high quality care, or if the health plans (and therefore the physicians and providers they contract with) are merely learning to cut corners. In Michigan, the call from some groups for a state mandated data system is an attempt to get at data on care delivery as much as it is to get a handle on costs. In turn, this puts pressure on managed care plans and traditional insurers to weed out "over-utilizers" or others whose practice patterns do not meet the plans' goals.

In the best of all possible worlds, outcomes data would be generated as completely and efficiently as possible, translated back to physicians as an educational tool, and then implemented in the improvement of process and the development of practice guidelines. There are many stumbling blocks along the way, and fear of the data being used in a punitive manner is chief among them. Physicians fear the data will be used against them, and that the resultant guidelines will be so rigid and static as to lead to "cook-book" medicine. The Michigan State Medical Society approved a set of data principles in 1994 that firmly state that any kind of physician specific data collection should have as its primary

purpose improvement of patient health and the maximization of quality and value, rather than just minimization of cost. These principles firmly reinforce that any data collection and analysis should have input from actively practicing physicians and should be primarily for the education of physicians.

Physician input critical

If, indeed, someone is going to do the measuring regardless, then physician involvement in the development and refinement of these measurements will be extremely important. Part of this involvement may lead to better education of employers, health plans, and consumers about the importance of using proper data sources, the need for appropriate data collection and assessment methodologies and relevant risk adjustments, and safeguards against skewed or misleading results or unauthorized disclosure. As John E. Wennberg, MD, MPH, said at the November 1995 MSMS Masters Series conference on outcomes measurement, black boxes developed by proprietary organizations without physician input are unacceptable and not in the best interests of patients or physicians.

The MSMS Advisory Committee on Medical Economics, chaired by John E. Billi, MD, has been charged with developing educational programs on outcomes research and related quality and data issues, providing assistance to physicians considering outcomes tools, developing expertise on legal issues surrounding such data, and identifying physician members with expertise in this area. Specific tasks related to this agenda have been referred to the Subcommittee on Physician Data, chaired by Paul O. Farr, MD. This same subcommittee developed the principles on physician specific data release and is monitoring the state data bills. Part of the challenge of this group, in its role as advisor to the MSMS Board of Directors, is to ensure that outcomes studies and other efforts at quality measurement are directed at improving health care delivery and ultimately health status, not just for sheer cost containment or political purposes. ■

The author is chief of health care research for MSMS.

Wennberg presentation available on video

John E. Wennberg, MD, MPH, director, Center for Evaluative Clinical Sciences, Dartmouth Medical School, presented information on the history of outcomes research and his new work on informed medical decision making at the November 1995 MSMS conference on outcomes measurement. Doctor Wennberg's presentation, "Variations, Outcomes, Preferences and Prostate Disease," is available on videotape from MSMS. Cost of the video, including shipping and handling, is \$10. To order, contact Angela Criswell a MSMS at (517) 336-5723.

Physicians speak out on outcomes measurement

By Karen Bouffard

Michigan Medicine interviewed physicians from private practice, public health, the insurance industry and major employers, to find out what they think about the impact and future of outcomes measurement. Here is what they said:

All of those interviewed participated in the November 1995 MSMS Conference on Outcomes Measurement.

"Prior to this healthcare revolution we're in, we as physicians and hospitals worked independently and separately, and now we're being called upon by our society to be accountable for what we do. The only way we can measure accountability is to measure outcomes that demonstrate we are doing the best we can for the communities we serve."

"A concern is that often you're using data that was not designed to measure clinical quality, and you're using it to make decisions that affect clinical quality. Data may show that there are 50 orthopedic surgeons out there whose hip surgeries cost more than everybody else's — but it won't show that these are doctors who specialize in doing the most difficult surgeries."

-Roland D. Mambourg, MD, Vice President Physician Integration, Mercy Health Services, Farmington Hills.

"The only way of doing outcomes measurement is to do very carefully designed studies, involving physicians, epidemiologists and statisticians, to ascertain the course of disease, success or failure of therapy, and costs both direct and indirect — as well as patient satisfaction."

- Rhoda M. Powsner, MD, JD, MHSA, Physician Consultant, Ford Motor Co.

"Physicians need to understand outcomes measurement because it is the benchmark by which we will all be judged by the payers and the patients in the future. One of my next goals for MSMS is that it will develop programs to meet the needs of doctors who are interested in learning and applying the meth-

odology of W. Edwards Deming, PhD. His methodology is very powerful. It's a systematic method of looking at the processes that lead to an outcome. It would be my hope that doctors would become familiar with his philosophy and methods, and become expert in applying them in delivering health care."

-Fred E. Patterson, MD, Radiologist, Foote Hospital, Jackson

"In surgery, it's going to be very difficult to assume one norm as an outcome for a given procedure without considering the associated illnesses and degree of severity. The danger is that the outcome of every procedure must be on target when in fact the health and risk factors of every patient may vary considerably. We need to have a category for every potential associated illness that a patient carries, and relate that to the surgery in order to have a meaningful outcome. It will take years to develop that kind of data base."

-Carlos A. Dall'Olmo, MD, Vascular Surgeon, Flint

"Outcomes measurement is related to evidence-based medicine. There are many types of evidence: The best comes from randomized control trials; a lower level comes from epidemiologic data; and the third would be practice-based outcomes. My own view is that randomized control trials teach about what is possible, and practice-based outcomes teach about effectiveness — what real world outcomes are as a result of what we do. If we combine the outcomes of what we all do as a necessary component, and clinical judgement as a sufficient component, I think we come out with the best plan of action for our patients."

- David R. Rovner, MD, Professor of Medicine, Chief of Endocrinology and Metabolism, MSU College of Human Medicine

"As medical director of a health plan, I define our goal as the best outcome for each individual patient."

To achieve this goal, we would like to assist physicians in providing the best clinical practice. By doing so, patients will continue to receive high quality medical care."

-Marshall G. Katz, MD, Medical Director, Omnicare Health Plan, Detroit

"The measurement of outcomes helps guide our efforts to improve quality, but no one ever received better health care just based on the measurement of outcomes. Just measuring how many eggs are broken when the carton gets home doesn't tell you where the problems are.

"Outcomes are highly susceptible to misuse, to the great disadvantage of patients and their physicians. When outcomes of individual physicians are released to the public and their employers, great harm can be done to both the patient and the physician. These groups always lack the information to accurately interpret and understand the outcomes, and they may act on incomplete or inaccurate information.

"There is a difference between measuring to judge, and measuring to improve in the spirit of total quality. MSMS has an opportunity to help physicians understand the appropriate use of outcome measurement. Outcomes are a valuable tool but if they're misused they will not improve the quality of care."

-John E. Billi, MD, Associate Dean of Clinical Affairs, University of Michigan Medical School, Ann Arbor

"Outcomes measurement is a most difficult task, but I believe it will become more prominent and important as time goes by. It helps physicians practice better medicine."

-Edward M. Cohn, MD, Neuro-Ophthalmologist, William Beaumont Hospital, Royal Oak

"It is extremely useful when the outcome measures are shown to be accurate and valid. The state of the art now is in its infancy. It has to advance

more, and case mix and severity adjustment all have to be considered. Alongside that, the future is incredibly promising, but it's going to take several years from where we are today to realize the full value and impact of true outcomes measurement."

-Douglas R. Woll, MD, Chief Medical Officer, SelectCare Inc., Troy

"If you consider that 80 to 85 percent of patients undergo some kind of imaging during a hospital stay, and 75 percent of diagnoses are based on some kind of imaging study, then you can see that radiology is in a pivotal role.

"The outcomes we routinely deal with are diagnostic outcomes, but in the future, because of issues of costs and appropriateness, we have to think about higher level outcomes — such as, for example, what the outcome is for society if we decide to do, or not do, an obstetric ultrasound in a given population of people. These are difficult decisions for society to make, but they have to be made. These are tremendous issues."

-Robert L. Bree, MD, Professor of Radiology and Director of Research, Department of Radiology, University of Michigan Medical Center

"For a variety of reasons, payment for healthcare services is changing dramatically, and accountability for the results is a major force in determining what items and services are most essential. The problem is, most of the time people and organizations that pay for services have had to rely on other kinds of measurements, such as number of patient visits, number of babies delivered. But these in and of themselves aren't the most meaningful measurements to make. Assessing the outcomes of the services that are provided would be an ideal way to focus on those services that give the best results and are of the greatest benefit to the patient."

-Giovannino A. Perri, MD, Medical Consultant, Medical Services Administration, Michigan Department of Social Services

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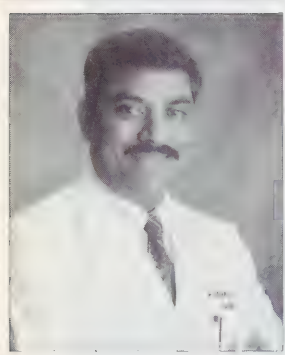
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AppaRao Mukkamala, MD

The silence between the thoughts

By Karen Bouffard



"If your mind is concentrated on an ideal, then one achieves more happiness when it is fulfilled. But if the desire is shallow and selfish, then the happiness is very short-lived."

Throughout his 1994-95 term as president of the Genesee County Medical Society, AppaRao Mukkamala, MD, wrote a regular "President's Message" in the Society's monthly publication, *The Bulletin*. His topics ranged from physician work force policy in the era of Newt Gingrich, to the need for diversity and unity among the Society's membership. One listed, in A to Z format, 26 reasons to join the AMA. Another provided a tongue-in-cheek "medical history and physical" of the Society, including a systemic review, psychological examination, and complete treatment plan.

A few articles though, dealt with a level beyond politics or medicine; beyond body, mind or intellect. It is a level Doctor Mukkamala calls the "absolute substratum," where the body and mind are transcended. It exists in the empty spaces within and between the atoms of our bodies. It is essential; it never changes, though the atoms that make up our bodies are ever-changing. As a Hindu, and as a physician, Doctor Mukkamala believes that answers to life's mysteries are here. It is to this place each day that he retreats, in a special room of his home containing candles, incense and Meditative books; a room designed for prayer and Meditation.

"I Meditate daily. It gives me mental equanimity and the power of concentration," says Doctor Mukkamala, 49, who is chair of radiology and vice chief of staff at Flint's Hurley Medical Center. "The mind is a flow of thoughts, just like a river is a flow of water. The clearer the water, the clearer the river. The cleaner the thoughts, the cleaner the mind. The more focused the thoughts the more concentrated the mind. The purpose of Meditation is to improve the quality and decrease the quantity of the thought-flow.

"The outside world, the scientists and politicians, try to improve our standard of living,"

he adds, "but Meditation and religion improve the standard of life."

Doctor Mukkamala describes Hinduism as a religion that "preaches that a Christian should be a better Christian, a Hindu should be a better Hindu, a Muslim should be a better Muslim and a Jew should be a better Jew." Doctor Mukkamala has used Meditation to try and achieve this in his own life.

A native of India, Doctor Mukkamala was the seventh of 10 children born to a middle class

paddy farmer in Budhavaram, a village of about 100 families in the State of Andhra Pradesh. Doctor Mukkamala's father carefully chose the profession of each of his five sons. One was to become a farmer like he, and the others a geologist, a mechanical engineer, and a dentist. Doctor Mukkamala was to become a physician.

Doctor Mukkamala met his wife Sumathi, a pediatrician, while at medical school in India. In 1970, he and Sumathi moved to Pittsburgh, Pennsylvania, where Doctor Mukkamala did his internship at St. Margaret's Hospital. In Pittsburgh, their son Srimi, nicknamed "Bobby," was born. Now 24, Bobby is a first year ENT resident at Loyola in Chicago. In 1972, the couple moved to Michigan for Doctor Mukkamala's surgical residency at Mt. Carmel Hospital in Detroit. After one year, the couple decided they did not want to both be clinicians while raising children. Instead, Doctor Mukkamala began a radiology residency at Flint's Hurley Medical Center, joining the staff there in 1975. Their daughter Aparna, 21 was born in Flint in 1974. She is now studying medicine at India's Manipal Institute of Higher Education.

If you ask Doctor Mukkamala what is most important to him in life, he will tell you that it is to be Happy. What is happiness? It is the

"The mind is a flow of thoughts, just like a river is a flow of water. The clearer the water, the clearer the river. The cleaner the thoughts, the cleaner the mind. The more focused the thoughts the more concentrated the mind."

fulfillment of his desires. "If your mind is concentrated on an ideal, then one achieves more happiness when it is fulfilled. But if the desire is shallow and selfish, then the happiness is very short-lived," he says. "Happiness is a state of mind," he add. "One way to stay happy is to reduce the number of desires one has."

One thing that makes Doctor Mukkamala happy is yearly journeys to his 100-year-old ancestral home to visit with the large extended family that remains in India. Another is charitable work in both India and the US.

In India, he is a supporter of Hari Har schools, which adopt small orphans or indigent children at age six or seven, feed, clothe and school them, and teach them a vocation. It is hoped that when these children reach adulthood, they will return to their communities to share the benefits of what they have received. In the US, he is national president of Chinmaya Mission West, a charitable Hindu organization. He is also vice president of Seva, Inc., a philanthropic organization based in Washington, DC. Additionally, he served as president of the American Association of Physicians of India, a 10,000 member organization, in 1992.

"I want to contribute something back to society in this country where I make a living," he says. "It makes me feel good. Makes me happy."

For Doctor Mukkamala, life is a spiritual

journey. In 1978, he became a vegetarian, believing he does "not need to take a life to sustain this life." For many years, he says, he was "blessed" with yearly week-long visits from Swami Chinmayananda, his Guru, and leader of the Hindu religion, who died in 1993. A spiritual milestone for Doctor Mukkamala and his wife was a 1994 pilgrimage involving a climb in the H i m a l a y a n Mountains to four ancient temples. The pilgrimage was made on mule and by foot, and required scaling peaks 13,000 feet above sea level. Medicine, too, is an important part of his spiritual journey.

"I classify myself as a person that wants to work, that wants to do things as opposed to someone who is more an introvert and lonely," he says. "I believe we're on earth to accomplish something; for me that's medicine. My work is my hobby. I honestly love what I do."

In Meditation, his journey continues. "What one would like to achieve is a state of thoughtlessness," he says. "You should become the witness to your own thought. You are the witness; you are not the thinker."

"By nature, we are the silence between the thoughts. That's the real me, with a capital 'M.'"



The author is a Williamston, Mich.-based freelance writer.



Doctor Mukkamala cherished his visits with his Guru, Swami Chinmayananda, leader of the Hindu religion.



Doctor Mukkamala with Guru Swami Chinmayananda.

Dexter W. Shurney, MD

New vice president and corporate medical director of BCBSM

By William Kendy

"I'm looking forward to the challenge of the future and especially working with physicians to build a meaningful and long lasting relationship."



"The Blues shouldn't be seen as a barrier, but as a facilitator. We want to decrease the 'hassle' factor and make life easier for physicians."

Those are the words of Dexter W. Shurney, MD, new vice president and corporate medical director of Blue Cross Blue Shield of Michigan.

Doctor Shurney, 37, earned his medical degree in 1983 from Howard University College of Medicine in Washington, DC. He holds an MBA from Mercy College in Detroit and earned his BS from Loma Linda University in California. During his 10

years with the Blues, he has held a number of pivotal positions, including senior associate medical director and HMO medical director.

Doctor Shurney's unique combination of medical, financial and administrative experience is what allows him to partner with and serve all the different professional components of the health care industry.

Doctor Shurney points out that the Blue's constituents encompass a number of "publics," including employers, patients, subscribers, physicians and hospitals, all of which require attention to quality management initiatives.

"We represent a number of different constituents, and we want to make sure all relations are as strong as possible," he says. "The only way to ensure this is to bring value to all involved.

"One of our biggest challenges is to make it easier for physicians to work with us. The Blues shouldn't be seen as a barrier, but as a facilitator. We want to decrease the 'hassle' factor and make life easier for physicians.

"For example, we're moving toward a uniform

claim form and more consistency with medical policy," he says. "Right now, we sometimes use different criteria for different product lines and that's very confusing for doctors. We have the corporate support to make that criteria more consistent. We can improve the process.

"In addition, we need to provide information back to doctors, in terms of what they're doing, so we can become a meaningful feedback and learning resource," Doctor Shurney adds. "But this entails providing more than just cost data. Hopefully doctors can use us as a learning resource to better position themselves for the future, in terms of managed care."

Doctor Shurney feels that Blue Cross Blue Shield has recently continued to make significant strides in reaching out to the physician community in Michigan.

"Even as a physician advocate, I certainly can't single-handedly give Michigan physicians everything they would like to see from the Blues," he says. "But I hope they recognize that I understand their issues and am open to working closely with them to make things better. We view the physicians in the state as friends and allies."

What's in store for health care in 1996?

"It's going to be much more competitive," says Doctor Shurney. "Already 'for-profits' are entering the state. When 'for-profits' come into a community, they can quickly change the health care environment. Oftentimes, they make cuts in the services they offer strictly based on financial reasons, sometimes without regard to the overall community impact.

"In addition, 1996 is an auto negotiation year," continues Doctor Shurney. "Since health care is a significant part of those discussions, who knows what we, as an industry, will face." ■

The author is a Holt, Mich.-based freelance writer.



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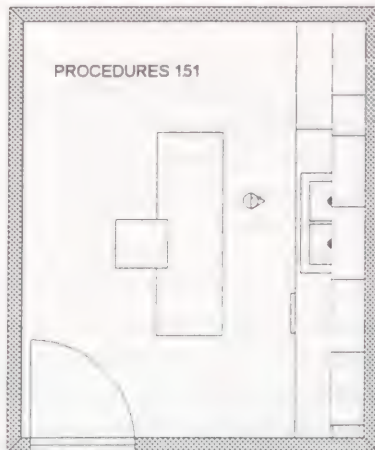
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Bringing History to Life

It's a labor of love for Tom George, MD

By William Kendy

It's ironic that an anesthesiologist, who makes a living making patients groggy, has produced an historical video that is anything but boring.



Colonel Joseph B. Westnedge served as the commanding officer of the Southwest Michigan National Guard.

Kalamazoo anesthesiologist Tom George, MD, is the writer and producer of an historical video outlining Kalamazoo's participation in World War I.

The video, entitled "Kalamazoo in World War I," recounts the life and times of Colonel Joseph B. Westnedge and the 126th infantry regiment he commanded.

What drives a doctor who, by his own admission, was not a history buff, to devote his time to producing his-

torical videos?

"I never was interested in history in college," said Doctor George. "I took the required classes...chemistry, biology...all the courses in the pre-med track. I was pretty deficient in American history."

The history bug hit Doctor George while he was in St. Lucia for a month long volunteer mission. There he met another volunteer anesthesiologist, Rueben Osario, MD, from Mexico. Doctor Osario was a recognized expert

on the life and actions of the bandit and revolutionary, Pancho Villa. Osario had extensively researched Villa, interviewing dozens of people who had known and ridden with him, including

some of his former wives and fellow soldiers, compiling diaries and archival material, which he incorporated into a book on Villa's life. This fascinated Doctor George, who decided there may be something to this history stuff after all.

The 100-minute documentary, which includes accounts from diaries, letters, newspapers, books, publications and actual military orders, were blended with hundreds of photographs of the 126th regiment in action. In addition, the video features World War I footage taken from the film, *The War to End All Wars*."

Doctor George spent more than two years researching, writing and producing the video. He became adept at tracking down historical photos and documents. One of his proudest acquisitions was the discovery of a photo of Katherine McKievel, one of the nurses at Base Hospital 11 in France, who was present at Westnedge's death. McKievel had written a letter of sympathy to Colonel Westnedge's widow.

"I tracked down her hometown in Sumter County, South Carolina and contacted the local museum," said Doctor George. "I was able to get a copy of the photo for just the cost of reproduction."

Doctor George interviewed and featured three soldiers from the 126th who had served directly with Westnedge and incorporated commentary from three local historians. In similar fashion to the techniques used in the well known PBS series, *"The Civil War,"* Doctor George added voices to the photos of the soldiers and individuals depicted in the video.

Westnedge commanded the 126th through such bloody campaigns as the Second Battle of the Marne and the Argonne Forest.

"The Argonne Forest encounter was the largest, bloodiest battle ever engaged in by American

The 126th Infantry,
commanded by
Kalamazoo's Colonel
Westnedge, prepared
for battle in the
trenches of France in
World War I.



troops," said Doctor George. "It surpassed even Gettysburg and World War II's Battle of the Bulge."

In a tragic twist of fate, Westnedge, having survived these actions with not so much as a scratch, died from tonsillitis just one week after the Armistice was signed. He was given a hero's burial in France. Later his body was transported back to Kalamazoo. Today, the main street in Kalamazoo, Westnedge Avenue, is named in his honor.

Doctor George produced a prior historical documentary, entitled, "Lincoln in Kalamazoo." The idea to produce this video came from

Doctor George's wife Sandy, who convinced Doctor George to do something special with the material he had accumulated. ■

The author is a freelance writer based in Holt, Michigan.

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Newsmakers

Bruce Becker, MD, vice president of Medical Affairs at Rehabilitation Institute of Michigan (RIM), has been selected by his peers to be included in the first edition of *The Best Doctors in America: Midwest Region* (1996-1997). Doctor Becker, of Grosse Pointe, joined RIM in 1993 as vice president of medical affairs. He also serves as an assistant clinical professor at Wayne State University School of Medicine.

Robert L. Bree, MD, a professor of radiology and director of research, Department of Radiology, University of Michigan Medical Center, is the newly-elected treasurer of the Society of Radiologists in Ultrasound, a Philadelphia, PA-based association. The purpose of the Society is to promote the advancement of diagnostic ultrasound.

Bruce M. Gans, MD, president of the Rehabilitation Institute of Michigan, Detroit, is senior vice president for rehabilitation and post-acute services at The Detroit Medical Center (DMC). This is a new position which was formed during a recent organizational restructuring of the DMC. In his new position, Doctor Gans will work to develop, implement and oversee a system-wide clinical services plan that meets market expectations as well as academic requirements. He

will continue as professor and chair of the Department of Physical Medical and Rehabilitation at Wayne State.

Michael Jule, DO, FACEP, is the new medical director of emergency services for Genesys Regional Medical Center, Flint. Doctor Jule will oversee emergency department services at the Flint Osteopathic Campus, the St. Joseph Campus, the Wheelock Memorial Campus and the new Genesys Regional Medical Center at Health Park in Grand Blanc Township.



B. Babu Paidipaty, MD, is the newly-installed chief of staff, St. Mary Hospital Medical Staff, Livonia. He is an internist and director of critical care at St. Mary. Other newly-installed officers include: **Martin Daitch, MD**, chief of staff-elect; **Vellore Ramakrishnan, MD**, secretary/treasurer; **Derek DeSouza, MD**, and **Vali Orandi, MD**, both Executive Committee members at large.

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine,

the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Obioma S. Agomuoh, MD,
Tecumseh

John Alter, DO, *Waterford*

John B. Austin, MD, *Ontonagon*

Walid M. Azmeh, MD, *Owasso*

E. Michael Balok, MD, *East China*

John P. Bartlella, MD, *Ypsilanti*

Mohammad A. Bashir, MD,
Saginaw

Jorge L. Batalla, MD, *West Bloomfield*

Kevin W. Beckman, MD, *Kalamazoo*

Valda L. Byrd, MD, *Troy*

Eugene A. Calabrese, DO, *Saginaw*

Michael A. Chames, MD, *Jackson*

Curtis R. Cook, MD, *Grand Rapids*

Carol L. Cooper, MD, *Midland*

Carmella D'Addezio, DO, *Bay City*

Brian C. DeBeaubien, MD, *Holland*

Fiorino DiGregorio, MD, *Clinton Twp.*

Roger G. Faix, MD, *Ann Arbor*

Bhupinder R. Gupta, MD, *East Lansing*

Ralph Harvey, MD, *Lansing*

Andrew M. Hauser, MD, *Berkley*

Dabiruddin M. Humayun, MD, *Flint*

Mark Joseph, MD, *Grand Rapids*

Jinho Kim, MD, *Grand Rapids*

Nehman L. Lauder, MD, *Southfield*

Marcia K. Lee, MD, *Midland*

Katherine A. Ling-McGeorge, MD, *Bingham Farms*

Louise E. Martin, MD, *Warren*

Eleanor M. Medina, MD, *Bloomfield Hills*

Collette L. Mercier, MD, *Saginaw*

Corrie A. Naasz, MD, *Dewitt*

Geraldine L. Pawlik, MD, *Detroit*

Brian L. Piazza, MD, *Flint*

Bonnie J. Putnam, MD, *Williamston*

Sudhir B. Rao, MD, *Big Rapids*

Craig Reynolds, MD, *Charlevoix*

Frank P. Schinco, MD, *Saginaw*

Eric Schreier, DO, *Midland*

John H. Schrieffer, MD, *Grand Rapids*

Raouf R. Seifeldin, MD, *Troy*

Bela S. Shah, MD, *Rochester Hills*

Ravinder Sharma, MD, *Marshall*

Douglas H. Slater, MD, *Grayling*

Arthur W. Tai, MD, *Ann Arbor*

Geraldine J. Terry, MD, *Livonia*

James Thornton, MD, *Grand Rapids*

Ann H. Uhle, MD, *Jackson*

Nancy J. Valentini, MD, *Canton*

Kermit White, MD, *Oak Park*

Amelia P. Wilson, MD, *Grand Rapids*

Brian Wittenberg, MD, *Petoskey*

Kenneth G. Wolf, MD, *Birmingham*

Subrahmanya S. Yellayi, MD, *Wayne*

Kimberly Zielke, MD, *Midland*

Deaths

Cornelius A. Alexander, MD, a retired Richland general surgeon, died December 5, 1995, at the age of 95. A 1929 graduate of University of Chicago-Rush Medical, Doctor Alexander was a member of Kalamazoo County Medical Society and MSMS.

J. Maxwell Cook, MD, MPH, a retired Lansing public health physician, died November 6, 1995, at the age of 75. A 1944 graduate of the University of Michigan Medical School, Doctor Cook was a member of the Ingham County Medical Society and MSMS.

Rosemary M. Dykema, MD, a Grosse Pointe Farms psychiatrist, died September 14, 1995, at the age of 72. A member of the Wayne County Medical Society and MSMS, Doctor Dykema earned her medical degree in 1947 from Johns Hopkins University.

Chester R. Hoyt, MD, a Grand Rapids physical medical and rehabilitation physician, died October 25, 1995, at the age of 42. A 1983

graduate of St. Luciz Health Sciences University, St. Lucia, Doctor Hoyt was a member of the Kent County Medical Society and MSMS.

Warren C. Lambert, MD, a retired Marquette obstetrician/gynecologist, died November 27, 1995, at the age of 88. A 1931 graduate of the Wayne State University School of Medicine, Doctor Lambert was a member of the Marquette /Alger County Medical Society and MSMS.

Jack Lapides, MD, an Ann Arbor urologist, died November 14, 1995, at the age of 80. Doctor Lapides was a world renowned urologist and professor emeritus of surgery at the University of Michigan Medical School. A 1941 graduate of the University of Michigan Medical School, he was a member of MSMS.

Harold O. Messmer, MD, a Utica general practitioner, died November 21, 1995, at the age of 63. A 1958 graduate of the Wayne State University School of Medicine, Doctor Messmer was a member of the Macomb County Medical Society and MSMS.

Carl H. Moberg, MD, a Grand Rapids cardiologist, died October 12, 1995, at the age of 73. He earned his medical degree from the University of Illinois in 1947. He served as president of the Kent County Medical Society in 1973.

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Gitesh Aggarwal, MD, P.O. Box 510, Ossining, NY 10562

Action, Date Taken: License Revoked, Fine \$5,000, 12-14-95

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Oscar Apoian, MD, 25441 W. Warren, Dearborn Heights, MI 48127

Action, Date Taken: License Suspended - 1 yr., Fine - \$10,000, 01-08-96

Reason: Unprofessional Conduct

Name: Frank P. Bongiorno, MD, P.O. Box 351, Wayne, MI 48184

Action, Date Taken: Probation - 2 yrs., Reprimand, 11-15-95

Reason: Sister State Disciplinary Action

Name: Linda Y. Callaghan, MD, 1946 Swan Pointe, Traverse City, MI 49686

Action, Date Taken: License Suspended - 6 mo. & 1 day, 11-15-95

Reason: Mental/Physical Inability to Practice

Name: Steven B. DeWilde, DO, 1209 10th St., Port Huron, MI 48060

Action, Date Taken: Probation - 1 yr., 01-08-96

Reason: Negligence - Incompetence

Name: Abdelkader H. Fares, MD, P.O. Box 433, Dearborn Heights, MI 48127

Action, Date Taken: Probation - 6 mo., Reprimand, Fine - \$6,000, 12-14-95

Reason: Criminal Conviction

Name: Frank D. Green, Jr., MD, 10705 Farrgout Hills Blvd., Knoxville, TN 37922

Action, Date Taken: License Suspended - 6 mo. & 1 day, 12-15-95

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Patricia J. Grena, DO, 746 S. Grand, Fowlerville, MI 48836

Action, Date Taken: Reclassified w/Unlimited License, 11-03-95

Reason: None Available

Name: J. Frederic Johnson, MD, 911 E. Nine Mile Rd., Ferndale, MI 48220

Action, Date Taken: License Suspended - 6 mo. & 1 day, 12-22-95

Reason: Negligence-Incompetence

Name: Malcolm K. Johnston, DO, 207 E. Bellevue, Box 475, Leslie, MI 49251

Action, Date Taken: License Limited - 2 yrs., Probation - 2 yrs., 12-04-95

Reason: Negligence

Name: David W. Law, DO, 2128 W. Jefferson, Trenton, MI 48183

Action, Date Taken: Probation - 3 yrs., 12-08-95

Reason: Mental/Physical Inability to Practice

Name: Leslie D. McBeath, MD, 9773 Abi Court, Plymouth, MI 48170

Action, Date Taken: License Suspended - 18 months, 08-22-94

Reason: Criminal Conviction - Alcohol Related, Substance Abuse

Name: Benjamin A. Monato, MD, 1643 Shaker Heights Dr., Bloomfield Hills, MI 48303.

Action, Date Taken: Summary Suspension, Dissolved, 11-01-05

Reason: None Available

Name: Munir A. Munshey, MD, 740 S. Emerick, Ypsilanti, MI 48198

Action, Date Taken: License Suspended - 3 yrs., Fine - \$5,000, 02-15-94

Reason: Criminal Conviction - Drug Related

Name: Lloyd S. Naramore, Jr., DO, 225 N. Court Avenue, Colby, KS, 67701

Action, Date Taken: License Revoked, 12-01-95

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Robert C. Posey, MD, 1219 E. Saginaw, Lansing, MI 48906

Action, Date Taken: By Order of the Court of Appeals, the Board's Final Order on Remand dated 04-20-95 is affirmed. License Suspended-6 mo., 01-01-96

Reason: Incompetence

Name: Jairam Rajan, MD, 1322 East Michigan Ave., Ste. 118, Lansing, MI 48912

Action, Date Taken: Reprimand, 10-30-95

Reason: Negligence

Name: Burr M. Rogers, DO, 990 44th Street, SW, Wyoming, MI 49509

Action, Date Taken: Reclassified w/Unlimited License, 11-03-95

Reason: None Available

Name: Michael H. Ross, MD, 9950 W. 80th Avenue, Arvada, CO 80005

Action, Date Taken: Limited License, 12-15-95

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Samuel M. Sefton, MD, 252 E. Lovell, Kalamazoo, MI 49007

Action, Date Taken: License Summarily Suspended, 11-20-95

Reason: Criminal Sexual Conduct

Name: David F. Simpson, MD, 1029 Balfour, Grosse Pte., Park, MI 48230

Action, Date Taken: License Permanently Surrendered, 11-15-95

Reason: Mental/Physical Inability to Practice

Name: Wayne M. Trinklein, MD, 11615 S. Hartel, Ste. 207, Grand Ledge, MI 48837

Action, Date Taken: License Suspended - 30 months, 01-01-96

Reason: Negligence-Incompetence, Lack of Good Moral Character

Education Through Travel with Michigan State Medical Society


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and
Their Families
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the All-Suite Renaissance*
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Two nights in Athens • Florence
two-night optional extension.
*From \$4,295, including
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May 23 to June 7, and
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*16-Day Adventure to the
Best of China, Featuring a
Cruise of the Three Gorges*
Three nights in Beijing • Two
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Chongqing • Four-night Yangtze

River cruise aboard the new
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international airfare from
Los Angeles*

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May 16 to 29, and
October 7 to 20, 1996
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*FLY FREE from most major North
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*13-Day Adventure
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Two nights in Fairbanks •
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*13-Day Journey to the
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July 30 to August 12, 1996
*14-Day Adventure to
Germany and Austria,
Highlighted by a Transit
of the Rhine, Main and
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(Rothenburg) • Bamberg •
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Valley • Regensburg • Passau •
Melk • Wachau Valley •
Durnstein • Vienna
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*From \$3,599, including round-trip
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New York (JFK)*

All prices include an Early
Booking Discount.

Prices are approximate
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Attn: Donna Trown
P. O. Box 950
East Lansing, MI 48823
or call 517-336-5735

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MSMS Meetings

February

28, Making the Rounds. Location: Watervliet Hospital, Watervliet, MI. Contact: F. B. "Tom" Plasman at MSMS at (517) 336-5724.

March

1-2, MSMS Joint Section Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Judy Marr at MSMS at (517) 226-5744.

11, Making the Rounds. Location: Manistee County Medical Society/West Shore Hospital Medical Staff, Manistee, MI. Contact: F. B. "Tom" Plasman at MSMS at (517) 336-5724.

20, MSMS Board of Directors Meeting. Location: MSMS headquarters, East Lansing. Contact: William E. Madigan, Executive Director, at (517) 336-5734.

28, Maternal & Perinatal Health Conference. Location: MSU Management Education Center, Troy, MI. Contact: Sarah Cressman at MSMS at (517) 336-5727.

28, Making the Rounds. Location: St. Luke's Hospital, Saginaw, MI. Contact: F. B. "Tom" Plasman at MSMS at (517) 336-5724.

April

11-12, Master Series Conference on Managed Care. Location: The Stouffer Hotel, Battle Creek, MI. Contact: Ginger Marenich at MSMS at (517) 336-7600.

18, Making the Rounds. Location: Borgess Medical Center, Kalamazoo, MI. Contact: F. B. "Tom" Plasman at MSMS at (517) 336-5724.

26, MSMS Regional Scientific Meeting. Location: Dearborn. Contact: Sarah Cressman at MSMS at (517) 336-5727.

26-28, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Donna Brown at (517) 336-5735 or Jeanne Miller at (517) 336-5726.

26, 28, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: William E. Madigan, Executive Director, at (517) 336-5734.

29-May 1, MSMS Alliance House of Delegates Meeting. Location: Park Place, Traverse City, MI. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

May

15, Rural Communities and HIV/AIDS. Location: Grand Traverse Resort, Traverse City, MI. Contact: Tom Seely at MSMS at (517) 336-5770.

20, Health Education Foundation Fourth Annual Golf Classic. Location: Country Club of Lansing, Lansing, MI. Contact: Dawn Reha at MSMS at (517) 336-7571.

22, MSMS/MSMS-A Capitol Check-Up Day. Location: Lansing, MI. Contact: Donna LaGosh at MSMS at (517) 336-5788.

AMA Meetings

March

10, AMA Leadership Conference. Location: Renaissance Hotel, Washington, DC. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty Society Meetings

March

6, Michigan Allergy & Asthma Society. Location: Novi Hilton. Contact: Jennifer Anibal at (517) 336-7595.

6, Michigan Dermatological Society. Location: University of Michigan. Contact: Jennifer Anibal at (517) 336-7595.

7-9, Michigan Association of Medical Education. Location: Holiday Inn South, Lansing. Contact: Melissa Wiegand at (517) 336-7586.

13, Michigan Chapter of the American College of Surgeons. Location: Novi Hilton. Contact: Melissa Wiegand at (517) 336-7586.

17, Michigan Society of Medical Assistants Board Meeting. Contact: Caroline Kimmel at (517) 336-7587.

21, Michigan Ophthalmological Society. Location: Radisson, Southfield. Contact: Andrew Lott at MSMS at (517) 336-7589.

April

13, Michigan Society of Anesthesiologists. Location: Ritz Carlton, Dearborn. Contact: Jennifer Anibal at (517) 336-7595.

18, Michigan Medical Group Managers Association Spring Conference. Location: Sheraton Hotel, Lansing. Contact: Andrew Lott at MSMS at (517) 336-7589.

18, Michigan Ophthalmological Society. Location: Radisson, Southfield. Contact: Andrew Lott at MSMS at (517) 336-7589.

26-28, Michigan Society of Medical Assistants Convention. Contact: Caroline Kimmel at (517) 336-7587.

May

1, Michigan Dermatological Society. Location: Henry Ford Hospital. Contact: Jennifer Anibal at (517) 336-7595.

1-3, Michigan Society for Respiratory Care Annual Meeting. Location: Dearborn, MI. Contact: Caroline Kimmel at (517) 336-7587.

3-4, Michigan Society of Internal Medicine Spring Meeting. Location: Southfield, MI. Contact: Caroline Kimmel at (517) 336-7587.

15, Michigan Allergy & Asthma Society. Location: University of Michigan. Contact: Jennifer Anibal at (517) 336-7595.

National Specialty Society Meetings

March

15, Medical Group Managers Association Legislative Conference. Location: Washington, DC. Contact: Andrew Lott at MSMS at (517) 336-7589.

Comment Line

If you would like to comment on an article in *Michigan Medicine*, or any other aspect of the magazine, please do not hesitate to contact Betty McNerney, Editor of Publications, at (517) 336-5749, or by FAX at (517) 337-2490, or E-mail at bmcnerney@msms.org

Our goal is to continuously improve *Michigan Medicine*. We welcome your participation in that process.

Rural Communities and HIV/AIDS

Conference

May 15, 1996

Grand Traverse Resort, Traverse City

HIV/AIDS has made its way into rural areas and small towns across the country. This growing presence poses a number of new challenges and concerns for health care providers. The Michigan State Medical Society will address many of the concerns confronting health care providers in rural areas of Michigan during a conference titled, "Rural Communities and HIV/AIDS."



Keynote speaker
Abraham Verghese, MD,
author of "My Own
Country: A Doctor's
Story," will share his
experiences of providing
HIV/AIDS care in rural
Tennessee.

This full-day conference will focus on issues including the challenges of providing HIV/AIDS care in rural settings, case management, and legal considerations related to HIV/AIDS. Concurrent sessions will discuss clinical care and medical care issues. And, a panel of persons living with HIV/AIDS will talk about their experiences and challenges they face.

The registration fee for this conference is \$65.

This conference also will be offered as a video conference in a number of sites in Michigan. For information about CME credits, or to register, please call MSMS at (517) 336-5776.

Financial Supporters and Meeting Planning Committee:

Michigan Department of Public Health
Michigan State Medical Society
Thomas Judd Care Center
Michigan AIDS Fund

Metro Health Foundation
MSU AIDS Education Project
Michigan Center For Rural Health
Michigan Health Council



Michigan State Medical Society

the Voice of 12,000 Michigan Physicians

EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

February

20, Bar-Levav Education Association Ongoing Seminar Series on "The Role of the Therapist in the Treatment of Obesity." Contact: Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours of Category I Credit.

23-24, Comprehensive Treatment Approaches for Adults with Childhood Trauma Histories. Location: Topeka, Kansas. Sponsor: The Menninger Clinic, Division of Continuing Education. Contact: Continuing Education at Menninger, 1-800-288-7377.

27, Bar-Levav Educational Association Ongoing Seminar Series, "Softening the Harsh Superego." Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours of Category I Credit.

28 - March 2, Advances in the Management of Infectious Diseases: Winter Update. Location: South Seas Plantation, Captiva Island, Florida. Sponsor: The University of Michigan Medical School. Contact: Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor,

MI 48106-1157, 313-763-1400. **Approved for:** 13 hours of Category I Credit.

March

2-3, Violence: Implications for Clinical Practice. Location: The Royal Sonesta Hotel, New Orleans, Louisiana. Sponsor: American Psychiatric Association, Office of Education. Contact: Maria Gorrnick at (202) 682-6145. **Approved for:** 14 hours of Category I Credit.

5, Bar-Levav Educational Association Ongoing Seminar Series, "Softening the Harsh Superego." Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours of Category I Credit.

7-9, Selected Hot Topics in Procedures. Location: Ashman Court Hotel, Midland, Michigan. Sponsor: The National Procedures Institute. Contact: Jill Frost, 4909 Hedgewood Drive, Midland, MI 48640, 1-800-462-2492. **Approved for:** 22.5 hours of Category I Credit.

10-15, Emergencies in Medicine. Location: The Yarrow, Park City, Utah. Sponsor: Detroit Receiving Hospital. Contact: Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours of Category I Credit.

10-15, 18th Annual Winter Psychiatry Conference: New Perspectives in Clinical Practice. Location: Topeka, Kansas. Sponsor: The Menninger Clinic, Division of Continuing Education. Contact: Continuing Education at Menninger, 1-800-288-7377.

12-16, Family Practice 1996 20th Annual Spring Review Course. Location: Towsley Center, Ann Arbor, MI. Sponsor: The University of Michigan Medical School, Department of Family Practice, Michigan Academy of Family Physicians. Contact: Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

18-22, PET and SPECT Imaging in Cancer Diagnosis and Treatment. Location: Ihilani Resort and Spa, Kapolei, Hawaii. Sponsor: Johns Hopkins Medical Institutions, Office of Continuing Medical Education. Contact: Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-2959. **Approved for:** 17 hours of Category I Credit.

(continued on following page)

Continued from previous page

22, Applied Clinical Informatics Symposium Topic on Information Systems of Immediate Importance for the Practicing Clinician. Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School, Department of Family Practice, Michigan Academy of Family Physicians. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

22-23, Infant Psychiatry: Models of Clinical Intervention for Infants & Families: A Multi-disciplinary Approach. Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

25-27, PET and SPECT Imaging in Cancer Diagnosis and Treatment. Location: Thomas B. Turner Building, Baltimore, Maryland. **Sponsor:** Johns Hopkins Medical Institutions, Office of Continuing Medical Education. **Contact:** Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-2959. **Approved for:** 18.5 hours of Category I Credit.

27-29, 17th Annual Clinical Sessions in Psychiatric Nursing: Maintaining Excellence in the Face of Change. Location: Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

28-29, Challenges and Changes in Obstetrics and Gynecology. Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

30, Transvaginal Ultrasound Workshop. Location: Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

Joint Section Meeting



*Calling Delegates and Representatives
to the MSMS Sections
for Young Physicians,
International Medical Graduates, and
Hospital (Organized) Medical Staffs*

*Make plans now to attend
the fifth annual
Michigan State Medical Society*

Joint Section Meeting

*March 1-2, 1996
Ritz Carlton Hotel, Dearborn*

featuring discussions on
The MSMS evaluation of Michigan health plans
the status of graduate medical education
managed care movements in Michigan

and featuring keynote speaker
Regina Benjamin, MD
Alabama family physician
first young physician member of the AMA Board of Trustees

For details on registration and hotel reservations, please call
Debbie Zannoth (YPS)
Betty McNerney (IMGS)
F. B. "Tom" Plasman (HMSS)
at MSMS headquarters, 517/337-1351, or fax requests to 517/337-2490.

CLASSIFIEDS

The rate for classified advertising in *Michigan Medicine* is 90 cents per word, with a minimum charge of \$50.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication. To place an ad, contact Bridgett Benton at (517) 336-5747.

POSITIONS OPEN

ESCAPE FROM THE ORDINARY!!

Needed! General Surgeon to work in our thriving rural family practice. Candidate should have skills in C-Section, Gyne & Laparoscopic surgery. 8 weeks vacation-CME. Consultants available. Only group in County with 3 referral centers 1 hr. away. Uniquely situated on I-94 half way between Madison and Twin Cities. Small town pride, excellent 51 bed hospital, great schools and recreation including all water sports, hunting, fishing, cross country & down hill skiing. Cohesive group of caring physicians!! Contact or send CV to Gary K. Petersen, Krohn Clinic, Ltd., 610 W. Adams St., Black River Falls, WI. 54615 Phone 715-284-4311.

FAMILY PHYSICIANS sought for rural and midsize communities in Iowa, Minnesota, North Dakota, South Dakota and Wisconsin. Contact: VHA North Central, 3600 West 80th Street, Suite 550, Minneapolis, MN 55431. Call collect: 612-896-3492, FAX 612-896-3425. Ask for Jerry Hess.

INTERNIST - Needed for rural Michigan practice to work in clinic and hospital practice. Send CV to Bay Area health Clinic, 615 South Euclid Avenue, Bay City, MI 48706. Telephone: (517) 686-9613.

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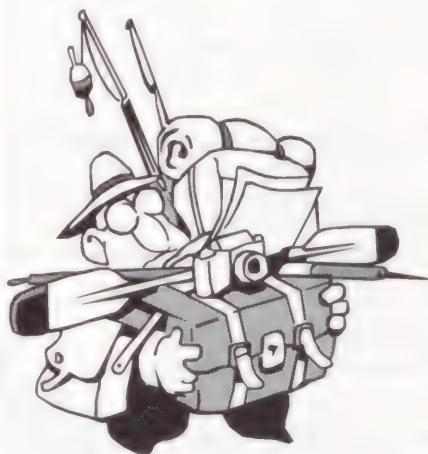
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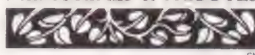
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Outcomes Measurement

It's useful as a guide, not as a straight-jacket

By B. David Wilson, MD

The buzzword in health care delivery these days is "outcomes measurement." The idea is that well-documented outcomes can be used as guidelines for physicians when making treatment decisions.

For many physicians, however, there lurks the fear of being forced to use outcomes as a mold into which each patient must fit. It has the ring of "cookbook" medicine without options.

And the questions come up: Who is going to do the measuring? How will outcomes be measured so that we are comparing apples to apples? When will enough outcomes be measured to make any real sense? Who will interpret all of this data? Will the outcomes measurements become the new yardsticks for payers? Practicing physicians must play a tremendous role in answering these questions.

We recently had the opportunity to look at some data collected by Blue Cross Blue Shield of Michigan which purportedly showed the top ten diagnoses, procedures and prescriptions that the Blues paid for in 1994. A friendly question was posed: What does this data show about the health status of Michigan citizens? After a half dozen phy-

sicians reviewed it, we all came to the conclusion that it didn't indicate much of anything very accurately. The data that they had was obviously good, but because of the lack of standardization under which it was collected and compiled, it was nearly useless for meaningful interpretation. We subsequently have offered the Blues our input on how to better collect this data so it could be more useful. My point is this: that collecting data will require a great deal of science behind it before it can have any validity in the clinical setting.

And even if outcomes data is collected and analyzed appropriately, we know that every patient is unique and cannot be pigeon-holed into a treatment plan. That was the point of outcomes guru John E. Wennberg, MD, MPH, the keynote speaker at a November 16-17, 1995, outcomes measurement conference presented by MSMS, Michigan Physicians Mutual Liability Company, Blue Cross Blue Shield of Michigan and the BCBSM Foundation. After extensive research into prostate cancer treatment, Doctor Wennberg concluded that "Quality in health care exists when: patient values decide the choice of treatment; informa-

tion on options is freely communicated; and treatment outcomes are efficiently produced and continually improved." Doctor Wennberg's presentation is available from MSMS on videotape.

An example of outcomes misuse, I believe, is by various "economic units" requiring mothers and babies to be discharged from the hospital within 24 hours of delivery. MSMS is supporting legislation to extend this to 48 hours. We really don't want to see it legislated at all, but we are fighting for a longer minimum in hopes that we can put the patient and her physician back in the driver's seat. This, and every other health care decision, must be made in the best interests of the patient, not because of the effect on economic credentialing.

It will be interesting to see how researchers propose keeping the human element in all of their data. And if they don't, it will be imperative that we physicians do. ■

Doctor Wilson is MSMS president.

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COVER STORY



Achieving Success

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Establishing an MSMS Physician Service Organization (PSO) could provide the crucial link physicians need to achieve success in today's increasingly competitive health care environment. So say members of the MSMS Task Force on Physician Networks who have been studying how best MSMS can help educate and prepare physicians for the future. How an MSMS PSO could be established and why the Task Force believes this is the best avenue for MSMS to pursue is the subject of this month's cover story.

Cover photo by: Roger Hill

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By Joan S. Stern

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As a followup to last month's cover story, this feature details some specific initiatives in outcomes research which are taking place around the state.

By Karen Bouffard



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New threats loom in Michigan.

By Paul C. Bartlett, MPH, DVM, James Sikarskie, DVM, and Mary Grace Stobierski, DVM, MPH

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Physician responds to article on well-being

I'm responding to the article on physician well-being which appeared in the January 1996 issue of *Michigan Medicine*. Malpractice suits certainly are a clear and present danger which truly may rob us of our careers -- we all recognize that. This threat we all seem to accept. When we arrive in court to face the plaintiff, we seem to always do better than we expected. A lot of us physicians know that it doesn't end there. Next to the malpractice case, and certainly more of a threat, is what our peers do to us.

In my 35+ years in medicine, I have yet to see an article, byline, television investigation, or any mention of what medical boards, peer review committees, attorney general's offices, administrative law judges and Department of Commerce members do which not only destroys careers, but often destroys *good* physicians. I can tell you what has happened to me (and probably others). No wonder suicide and depression are so common in the medical profession.

These "peer" physicians are quick to judge, are aggressive in dictating "punishment," and *answer to no one*. Judges enjoy making examples out of doctors. Most physicians enter into this setting in a trusting and optimistic and naive manner. This is a mistake. Our attorneys don't seem to coach us enough. I have found that attorneys don't take our defense serious enough. I'm talking about situations of hospital privileges, medical licensure, and malpractice insurance peer review.

My rules now:

1. In dealing with other physicians in any peer review or investigative process concerning you, *always* have an attorney present.

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There are others also!

I would like to keep all physicians from going through what I have.

Curt Graham, MD, FACS, FACOG

Kalamazoo

Michigan Medicine redesign receives praise

Kindly accept my sincere congratulations for the new format of *Michigan Medicine*. Simply put, it is a beautiful medical journal!

Having "been there" (as president of MSMS) in the 1970s, I feel quite qualified to judge what you have done. It is so great that it is truly exciting.

The format is striking and catches the eye. The new features, such as the Physician Profiles and Life's Pleasures, and the accompanying photographs are especially attractive and interesting. The art work and all the articles are equally top-notch.

This is a Journal that will proudly carry the message of our MSMS for many years to come and should contribute a great deal to the efforts of organized medicine to put some sense into the whirlwind that is engulfing health care delivery these days.

Brooker L. Masters, MD

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Question:

*How do you handle stress
in your life?*

“When there is a particular problem causing the stress, taking responsibility for the problem and fixing it alleviates the stress. When that’s not possible, we need some coping mechanisms -- things like good friends, a good mentor, journaling, meditation, physical exercise, planning...or just sitting in one place and being quiet.”

James J. Miller, MD, age 47
Internist, Lansing

“All of us get into rhythms in our lives, and how we perceive stress depends on how we manage the pace and balance our responsibilities. When the pace picks up, we’re thrown off balance. One answer is to feel successful at balancing all of our responsibilities. I cheat, and steal time for reading, a nap or to take a class. Currently I’m taking a class in photography; in the past I’ve studied French. I take my mind off the medical world by making sure I make time for myself in the real world.”

David C. Dunstone, MD, age 54
Psychiatrist, Kalamazoo

“I exercise every day. I get up at 5:30 in the morning, and do the StairMaster for a half hour. Then I work out with weights for 45 minutes, shower and go to the office. It’s a routine, and it works.”

Douglas A. Edema, MD, age 44
Family Physician, Grand Rapids

“I play squash. It allows you to get rid of a lot of energy, a lot of aggression -- and it’s a pretty good workout. The other thing I do is spend time with my kids. There’s nothing like a seven-year-old to relieve stress.”

Michael Kleerekoper, MD, age 51
Endocrinologist, Detroit

“I laugh a lot; try to find some humor in the situation; blame it on the full moon. When I leave the office, I

don’t do medicine. I try to keep some balance, and realize that if I drop dead tomorrow life will go on without me. I plan ahead to have some fun.”

Dawn E. Springer, MD, age 55
Family Physician, Mason

“I like to exercise -- ski, windboard, windsurf, bike ride. I’m also a Scoutmaster, and I like to go camping with the Boy Scouts.”

William Howard, MD, age 54
Internist, Traverse City

“I do things I enjoy, like personal computers, or playing the piano.”

Thomas L. Haynes, MD, age 47
Addiction Medicine Specialist, Grand Rapids

“You can get real angry about stress, or you can consider it a challenge. I tell my patients -- and a lot of them are physicians -- to have some kind of an active hobby to enjoy. Something they can do on a daily basis, year-round; not something like golf, or fly fishing, that you can only do a few months a year. I combine my love of classical music with my love of modeling. I have speakers mounted in my workshop and listen to the classics while building model airplanes.”

Richard H. Wakulat, MD, age 57
Internist, Petoskey

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax to (517) 337-2490, or e-mail bmcnerney@msms.org.

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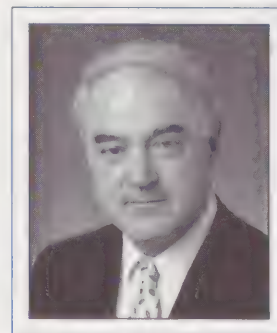
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Timely payment for medical services by insurers

By Richard D. Weber, MSMS Legal Counsel



Q: Are there any laws which require insurance companies or other third-party payers to pay claims for medical services on a timely basis?

A: The Insurance Code requires insurance companies to pay all claims on a timely basis. Failure to do so is deemed to be an unfair trade practice under the Insurance Code. In addition, benefits not paid on a timely basis shall bear interest at a rate of 12 percent per annum from a date 60 days after a satisfactory claim form was received by the insurer. The Insurance Code applies to all insurers doing business in Michigan, but does not apply to Blue Cross Blue Shield of Michigan.

Under the Nonprofit Health Care Corporation Reform Act, the BCBSM enabling act, timely payment of claims is also mandated by statute. Benefits payable to an insured shall bear interest at the rate of 12 percent per annum from a date 60 days after a satisfactory claim form was received by BCBSM. BCBSM must specify in writing the materials which constitute a satisfactory claim form not later than 30 days after receipt of a claim.

Q: What rights do the physician and the patient-insured have if an insurance company or third-party payer does not pay a claim for medical services in a timely manner?

A: The statutory rights under the In-

surance Code and the Nonprofit Health Care Corporation Reform Act accrue to the patient, not the physician. In addition, the physician has no legal rights under the insurance contract, because that contract is with the patient and not the physician. If the physician has a participating agreement with the insurance company or other third-party payer, the physician may have a direct claim against the insurance company. Participating agreements may require payment of claims within a certain time period, with the provision that interest will be assessed if the payment is not made within that time period. Absent such a participation agreement with the physician, however, the physician has no rights against the insurance company. The physician's rights are solely against the patient, who would then have rights against the insurance company under the contract of insurance or the statutory provisions.

Q: May a physician charge a patient interest for late payment of a statement for medical services?

A: Under Michigan law, a physician and patient may enter into an agreement for the payment of interest. If there is no agreement or prior notification and acquiescence by the patient that there will be an interest charge, interest may not be charged. The rate may not exceed five percent per

annum, unless the patient and physician have agreed in writing to an interest rate, but in any event it may not exceed seven percent per annum.

Q: How are these patient rights enforced?

A: A patient may file a claim with the Insurance Commissioner based upon the unfair trade practices section of the Insurance Code or the specific BCBSM statute. Insurance Bureau complaint forms are readily available. Upon receipt of a complaint, the Insurance Bureau contacts the insurance company or administrator and the insurer has 30 days to respond to the allegations. The Insurance Bureau then makes a determination as to whether the insurer's activities comply with the applicable laws. The Insurance Bureau forwards this determination along with a copy of the insurer's response to the patient/complainant. The patient has the right to pursue litigation if the Insurance Bureau resolution is unsatisfactory. ■

Mr. Weber is a senior partner with Kerr, Russell & Weber, Detroit.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to Betty McNerney, Editor of Publications, PO Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to bmcnerney@msms.org



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By Joyce Nurenberg, MSMS Reimbursement Ombudsman

Medicaid

Q. A Medicaid representative recently informed my group that Medicaid does not pay for supervision of Certified Registered Nurse Anesthetists (CRNAs). The Medicaid policy manual states, "when both an anesthesiologist and the anesthetist provide the anesthesia service, the number of time units entered in the quantity on the claim should be the total of time units calculated independently for the anesthesiologist and the anesthetist" (i.e., 15 minutes = 1 time unit for the anesthesiologist and 30 minutes = 1 time unit for the CRNA). Please clarify the Medicaid rules for billing for supervision of CRNAs.

A. Medicaid does not reimburse a physician for supervision or medical direction of CRNAs providing anesthesia services.

The Medicaid policy manual Chapter 3, page 8, which precedes the section noted above, also states, "Anesthesia charges are separately reimbursable only when rendered by an anesthesiologist/anesthetist who is in constant attendance during the surgical procedure for the sole purpose of rendering the anesthetic." If the anesthesiologist personally participates in the emergence and the induction procedures, the Medicaid program can be billed, based on 15-minute time units. If there is any other time that is spent administering the anesthetic, this time may be billed as well. The medical record should reflect the time actually spent in providing anesthesia.



MSMS Reimbursement Ombudsman, Joyce Nurenberg, (left) offers her expert advice on accounts receivable as part of an MSMS in-office consultation. For more information on this and other services, contact James Aluia at MSMS at (517) 336-7599.

In the case of the hospital employing or contracting with a CRNA, the hospital will bill for the time the CRNA spends administering anesthesia based on 30 minute time units. Medicaid contends that if the anesthesiologist provides medical direction or supervision only, and does not personally participate in administering anesthesia, then it is not a billable service. The hospital may be responsible for reimbursing the anesthesiologist for supervision as part of their administrative costs.

If the physician employs the CRNA, and both administer the anesthesia, the actual time spent by each may be billed to Medicaid. If

the physician participates in the induction, for example 15 minutes, and the CRNA provides anesthesia for the remainder of the surgery, say one hour and 12 minutes, then the bill to Medicaid would be one time unit for the physician and three time units for the CRNA. The claim would be submitted under the physician's ID number and the total quantity billed would be four.

Ombudsman's note: Tom George, MD, immediate past president of the Michigan Society of Anesthesia and Kumbha Bhatka, MD, explained to Medicaid representatives the team concept of providing anesthesia services. Vern Smith, PhD, director, Medical Services Administration, did agree to revise the policy in a budget neutral manner to recognize the team concept consistent with that of Medicare. He also noted that until the policy is changed, there can be no reimbursement by the program for supervision or medical direction of CRNAs by physicians.

This response was provided in consultation with Medicaid medical policy staff.

CHAMPUS

Q. I saw a patient who knew I did not participate with the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS) and who paid my bill on the date of service. As part of our normal process, the patient also signed an agreement to pay for charges not paid for by insurance. The patient later contacted

me after receiving her explanation of benefits and said that I could not bill her for the balance after Champus paid.

Is this true?

A. Effective with the November 1, 1993, Final Rule, the Health Care Financing Administration (HCFA) authorized CHAMPUS to limit balance billing amounts by nonparticipating physicians to 115 percent above the CHAMPUS determined allowed amount, not including deductibles and copayments. Private contracting is allowed if the patient agrees to do so. This is best accomplished by having the patient sign a waiver. Since CHAMPUS does not supply this waiver, physicians are advised to create a "CHAMPUS WAIVER" explaining the implications of the patient's signature.

Based on the above information MSMS legal counsel advised the patient is due a refund for the amount she paid above the 115 percent of the CHAMPUS allowed amount, not including copay and deductibles. It was felt that because the office was not aware of the federal limitation, an appropriate informed consent would not have been obtained from the patient.

MSMS Legal Counsel, Richard Weber provided the following answers to questions regarding no-fault auto inquiries.

No fault insurance

Q. Are physicians obligated to furnish written reports to a no-fault insurer upon request?

A. Yes. Section 3158 of the Michigan No-Fault Motor Vehicle Insurance Law requires a physician, hospital, clinic or other medical institution to furnish a "written report of the history, condition, treatment and dates and costs of treatment of the injured person" if so requested by the insurer.

Q. May the physician charge a fee for preparing the medical report?

A. Section 3157 authorizes a physician, hospital, clinic or other person or institution lawfully rendering treatment in such instances to charge a "reasonable" amount for the products, services, and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." This conclusion is supported by the Attorney General (Atty. Gen. 1980, No. 5622 p. 535).

Q. Can a physician withhold furnishing the report until payment is received?

A. There appears to be nonconclusive law, one way or the

other. Medical reports should not be withheld from physicians or the patient because of an unpaid bill for medical services.

The same patient concerns would probably not be applicable to withholding a medical report from an insurer until payment is made for the report. Therefore, MSMS legal counsel advises that, as a general proposition, a physician may insist upon payment before furnishing the report. ■

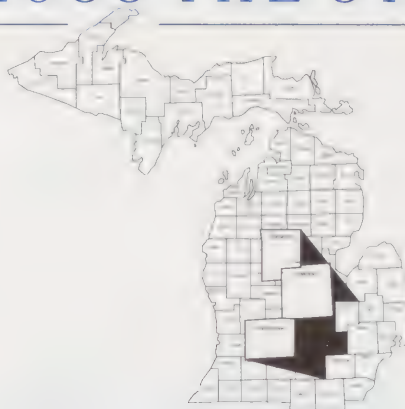
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Comment Line

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Our goal is to continuously improve *Michigan Medicine*. We welcome your participation in that process.



Washtenaw County

Medical Society addresses "Sex in the Year 2000"

A very popular and somewhat controversial resident of Washtenaw County will address the issue of "Sex in the Year 2000" during the March 12 meeting of the Washtenaw County Medical Society.

Sylvia Hacker, PhD, professor emeritus at the University of Michigan and a noted sex therapist, is a frequent guest on radio and television. She has appeared on several national programs including: "Main Street," an NBC television program for teenagers; "Real Personal," a CNBC program hosted by Bob Berkowitz; and "The Phil Donahue Show." She also hosts a local Ann Arbor Community Access show every month called "Sexy Minutes."

Genesee County

Medical Society Foundation supports HIV projects, free clinic

The Genesee County Medical Society Foundation has raised

\$300,000 since the Foundation was founded in 1989 for HIV-related projects in the greater Flint area. It also has raised funds in support of the Genesee County Free Clinic. Most recently, the Foundation raised \$5,000 for the Clinic and donated an additional \$1,000 to help fund the Clinic's annual volunteer dinner.

Three Genesee County physicians expressed their support for the Clinic by donating their honorariums from the first GCMS CME meeting held in 1996. They were: AppaRao Mukkamala, MD, H. George Dass, MD, and Kenneth Fawcett, MD.

GCMS participates in immunizations coalitions

A core group of Genesee County physicians are participating in two area coalitions aimed at improving the immunization rate in Genesee County and developing a county-wide registry to track immunization records. They are: Kalyani Misra, MD, Robert L. Clark, MD, Gary K. Johnson, MD, and Lawrence A. Reynolds, MD.

Oakland County

Free Health Day brings public, doctors together

Early this month, the Oakland County Medical Society sponsored "Health Day '96" -- a program aimed at bringing area residents and physicians together to discuss health care issues and concerns.

The half-day program, held at The Community House in Birmingham, began with "Dialogue with Doctor" classes that included short presentations by physicians, followed by question-and-answer opportunities. This year's topics included: aging; gynecology; urology; neurology; cardiac surgery; dermatology; ophthalmology; rheumatology; and gastroenterology.

Several Oakland County physicians participated in the program. They were: Mary Roth, MD, Jerome Rose, MD, Joann Smith, MD, David Harold, MD, Steven Newman, MD, Sherry Viola, MD, Nicholas Tepe, MD, Stella Bulengo-Ransby, MD, Jeffrey Kalt, MD, Steven Landau, MD, Niru Prasad, MD, Martin Noveck, MD, Jeffrey Leider, MD, Ruth Bateman, MD, Eugene Gelzayd, MD, and Bradford Gelzayd, MD. ■

What is happening in your neck of the woods?

Michigan Medicine would like to develop and expand this monthly feature to include news from various sources across the state. That includes county medical societies, specialty medical societies, physician organizations, business coalitions and other organized groups involving physicians. Send your news by mail, fax, e-mail or phone to Tom Seely, chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950; fax (517) 337-3490; e-mail tseely@msms.org; or phone (517) 336-5770. Photos in either black and white or color are accepted and will be run on a space available basis.

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Dear Colleagues:

The mission of the BCBSM Foundation is to improve the health and medical care of the citizens of Michigan. We currently have six grant programs supporting Michigan physicians and researchers.

We're pleased to share information with you regarding one of our newest grant programs entitled "The Physician Investigator Research Award Program."

Responding to the interests of Michigan physicians, this program provides \$10,000 to physicians who wish to explore the merits of a new research idea, conduct a small research project or even to assess the feasibility of a research project.

Although the program is less than a year old, we've funded several interesting projects. Each of our projects is related to enhancing the quality of care, containing costs and improving appropriate access. For example, we've awarded a grant to Lee Green, M.D., a family practitioner at The University of Michigan for a study aimed at measuring quality indicators of asthma care. Another grant was made to Deborah Banazak, D.O. at Michigan State University to conduct a small study surveying the strategy used by nursing facility medical directors for handling depressed patients.

If there is a topic that you believe warrants study or if you have a possible project in mind, contact the BCBSM Foundation for an application or to discuss your interest.

Sincerely,

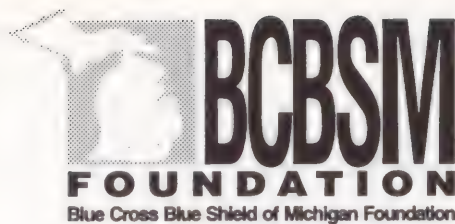
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PHYSICIAN INVESTIGATOR RESEARCH AWARD PROGRAM

IMPROVING MICHIGAN HEALTH CARE

The Blue Cross Blue Shield of Michigan Foundation is pleased to present, the Physician Investigator Research Award Program (PIRAP). The program will provide support of \$10,000 to explore the merits of clinical, medical or health services research, performed by physicians.

INTRODUCTION The BCBSM Foundation is the philanthropic affiliate of Blue Cross and Blue Shield of Michigan. Incorporated in 1980 as a non-profit 501 (c)(3) organization, the Foundation has approximately \$1 million available for health and medical care research, annually.

PROGRAM AIM The Physician Investigator Research Award Program is for physicians who have an interest in health and medical care research. The purpose of this program is to provide "seed" money to physicians to explore the merits of a potential research idea. The proposed project might be in the form of a pilot study, feasibility study or a small research study. Grants of \$10,000 are available for research related to the quality of care, cost and access to health and medical care, including bio-medical, clinical and/or health services research.

APPLICATION

PROCESS Applications for the Physician Investigator Research Award Program are accepted throughout the year. In addition to the application, requests for funding should include a brief prospectus of three to five pages delineating the project, nature of the research question to be addressed and the proposed approach of the study. Requests will be reviewed by the Foundation board of directors three times a year.

ELIGIBILITY OF APPLICANTS

The BCBSM Foundation seeks applications from physicians, interested in research, who are licensed and domiciled in the state of Michigan. Applicants may include physicians working in research environments such as medical schools or university affiliated hospitals, health care systems as well as physicians working in non-profit agencies or in private practice.

INFORMATION

All requests for information and applications should be directed to:

Program Officer
Physician Investigator
Research Award Program
Blue Cross Blue Shield
of Michigan Foundation
600 Lafayette East, B243
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Does Michigan have a shortage or a surplus?

By Stephen A. Mykytyn

Several recent studies seem to be drawing conflicting conclusions about the nation's physician supply. Many conclude there is a surplus.

A particularly thorough examination of the current physician supply is offered by the Institute of Medicine (IOM) in a recent report entitled, "The Nation's Physician Workforce." The IOM study concludes that the US has a physician-to-population ratio of 180 per 100,000. It suggests that a ratio of 140 per 100,000 would be sufficient to provide adequate health care with present levels of managed care penetration. However, this method of defining physician surplus as an exceedingly high physician-to-population ratio fails to take into consideration the actual geographic distribution of physicians or their specialties. Many areas and populations continue to suffer from physician shortages, especially in primary health care.

Supply versus access

Many states, including Michigan, are currently struggling under a widespread shortage of primary care physicians. The number of physicians practicing in Michigan has been steadily increasing, although many areas, particularly rural regions, continue to suffer from a critical shortage of health care providers. A 1993 study by the NACHC found that 15 percent of Michigan's population lacks access to primary health care services. This situation exists even though Michigan had a physician-to-population ratio of 201 per 100,000. This illustrates the paradox of too many physicians but not enough health care. Obviously, the market forces of supply and demand are not exerting enough force to cause physicians to move to underserved areas. So, although there is a general surplus of physicians, there is not what might be termed a surplus of available care.

As managed care increases its presence in the state, the problem of specialty surpluses will be exacerbated. In the May 1995 edition of *Michigan Medicine*, the Michigan State Medical Society's *Survey on*

Practice Characteristics showed that over 69 percent of physicians belonged to an HMO and almost 74 percent belonged to a PPO. Of the physicians who did not yet belong to a managed care plan, almost 49 percent were considering joining one. This decreases the number of specialist physicians required to adequately serve a population by using primary care physicians more extensively. This would suggest a further increase in the demand for primary care physicians. However, most studies suggest that the current supply of primary care physicians would be able to meet this need. Any recommendations to the "specialty imbalance" that only address the numbers of physicians without considering other facets, such as maldistribution and service population demographics, will be inherently flawed.

Recommendations

In November 1995, the Pew Health Professions Commission called for a reduction in the number of new physicians by completely closing some medical schools rather than by downsizing the class sizes. The IOM's study challenges this recommendation by asserting that this could increase the current misalignment of medical coverage by further concentrating physicians in urban areas as well as decreasing the representation of minorities and women. Nelson Tilden, president of Medical Search Institute - a nationally-renowned recruitment think tank, points out that current physicians entering the workforce are seeking practice careers that differ significantly from the traditional physician practice. Current models of physician demand necessarily rely on the historic

"...although there is a general surplus of physicians, there is not what might be termed a surplus of available care."

career choices made by an established physician population. For example, few young doctors are interested in working 70 to 80 hour work weeks. Also, according to Tilden, females are making up an increasingly larger proportion of physicians (from 1991 to the year 2000, the number of female physicians is expected to increase by 49.3 percent while the male physician population is projected to grow by only 6.9 percent). This is significant because many female physicians are also married to professionals and express a desire for flexible work environments, possibly including part-time or job sharing positions. Both of these situations suggest that physician replacement will not be occurring at a one-to-one ratio. Tilden also points out that data from the American Academy of Family Physicians show about 15,000 family practitioners (25 percent of the US family practice population) are over age 60 and can be presumed to be planning on retiring within the next decade. In Michigan, 55 percent of all physicians are considering retiring before age 65. Again, this needs to be factored in when considering future physician supplies, particularly in primary care.

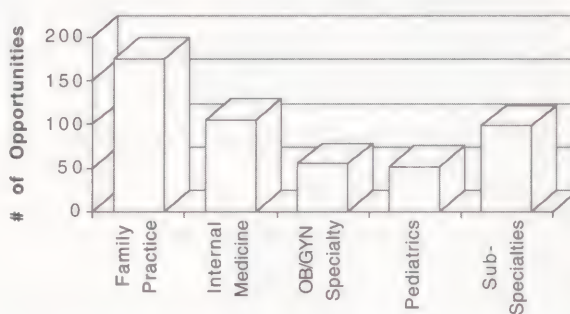
The IOM study also points out that decreasing the number of medical school graduates is not a viable solution to the current surplus because it does not correctly address the situation. "...although the number of US medical school graduates has remained constant in recent years, the number of physicians in residency training continues to increase." This is due to international medical graduates (IMGs) attending residency programs in the US.

IMGs finishing residencies have been identified as a possible solution to providing primary health care services to underserved areas. An IMG practicing in an underserved area can remain in the US after the completion of his/her residency program. However, this is only a temporary solution because many of these physicians show the same reluctance to practice in underserved areas as do US medical graduates (USMGs). Additionally, IMGs specializing in internal medicine choose to subspecialize at roughly the same frequency as USMGs. This only adds to the excessive representation of non-primary care specialties and does not address concerns of primary care maldistribution.

A result of shortages, geographic maldistribution, and cost reduction is that health care professionals, such as advanced practice

nurses (APNs) and physician assistants (PAs), are taking on responsibilities traditionally assumed by physicians in increasing numbers. This is an effective way to provide health care to populations that are currently not receiving the medical attention they need. Managed care systems also utilize APNs and PAs as a means to efficiently diagnose and treat patients in some instances. Since in Michigan there are currently only about 2,200 APNs and PAs, it is doubtful that these health care providers will reduce or replace the need for primary care physicians, given current shortages.

Physician Opportunities on MOM by Specialty as of February 1996



One organization that is addressing the current health care situation in the state is Medical Opportunities in Michigan (MOM). MOM, a service of the non-profit Michigan Health Council, has over 400 primary care practice opportunities currently listed statewide. It seems difficult to rectify this obvious demand with the statement that there exists a surplus of primary care physicians. Medical Opportunities in Michigan is a candidate controlled database of statewide opportunities designed to match physicians, especially primary care specialties, and mid-levels (APNs, PAs and physical therapists) with practice opportunities in Michigan. For more information on MOM, call 1-800-479-1MOM. ■

Stephen Mykytyn is the health care specialist at Medical Opportunities in Michigan. He matches physicians (both primary care and specialists) with practice opportunities throughout the state. He also demonstrates the MOM database to primary care residency programs and provides the residents with information to assist them when making the transition to a practice environment.

"As managed care increases its presence in the state, the problem of specialty surpluses will be exacerbated."

Federal Labor Laws

Are you in compliance?

By Joan S. Stern

The U.S. Department of Labor, Wage and Hour Division, receives a significant number of complaints from health care employees regarding wage and hour violations by their employers. It is my belief that violations occur because some physicians are not familiar with the current laws. To help educate physicians, and reduce the number of violations, the following article describes two key laws—the Fair Labor Standards Act and the Family and Medical Leave Act.

Fair Labor Standards Act

Do you pay employees for all hours worked? Do they report early, work through lunch or stay late without being paid or without being paid at time and one-half, if they work over 40 hours? These violations occur frequently in the doctor's office. Even if your staff wants to "finish up," these employees must be compensated for all hours worked.

"Hours worked" include all time an employee must be on duty, or on the employer's premises or at any other prescribed place of work. A workweek is a period of 168 hours during seven consecutive 24-hour periods.

The FLSA provides 40 hours as the maximum number that an employee subject to its provisions may work for an employer in any workweek without receiving additional compensation at not less than one and one-half times the regular rate at which the employee is actually employed. The hourly rate is the rate actually paid the employee for the nonovertime week for which he is employed.

Exemptions

Some employees are excluded from the minimum wage and overtime pay provisions by specific exemptions. Exemptions are generally narrowly defined under the FLSA. For a person to be exempt from the minimum wage and overtime regulations, that person must be in a

bona fide executive, administrative, or professional capacity. This employee must also be paid on a salary basis. This amount cannot be subject to reductions for absences occasioned by the employer, an example of which would be a holiday closing. Deductions may be made, however, when the employee is absent for a day or more for personal reasons or sickness if the deduction is made in accordance with a bona fide

plan, policy or practice, and after he has exhausted his leave allowance thereunder. *If your employee is not the office manager, with supervisory authority, that employee is probably not exempt. Simply paying a salary to an employee does not exempt them from overtime.*

The Family and Medical Leave Act

Physicians who employ more than 50 employees are covered under the Family and Medical Leave Act (FMLA) of 1993. FMLA allows an "eligible" employee of an employer who is covered under the Act to take a job-protected, unpaid leave if the employee has earned or accrued it, for up to a total of 12 workweeks in any 12 months because of: the birth of a child and to care for the newborn child; the placement of a child with the employee for adoption or foster care; the employee is needed to care for a family member (child, spouse or parent) with a serious health condition; or the employee's own serious health condition makes the employee unable to perform the functions of his or her job.

This article may have raised more questions than it answered. I will gladly respond to you individually if you want clarification or guidance. Please contact me at (517) 377-1790. ■

The author is a wage hour investigator with the U.S. Department of Labor Wage and Hour Division.

Knowledge of the wage and hour laws may preclude the large number of complaints we receive with regard to the medical industry.

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Russ Coile is a futurist specializing in the health industry. He is the president of the Health Forecasting Group, based in Southern California. As an independent consultant, he provides market forecasts and strategic advice to a wide range of U.S. hospitals, medical organizations, and health care companies.

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Outcomes Measurement

A review of Michigan initiatives

By Karen Bouffard

Last month's Michigan Medicine cover story put the spotlight on outcomes measurement, detailing why this has become a top research priority for the 1990's. The following article takes a look at some specific initiatives in outcomes research which are taking place around the state.

Initiative #1 - Radiology services

Robert L. Bree, MD, professor and director of research within the Department of Radiology, University of Michigan Medical Center, has long been interested in appropriate utilization of radiology services. "I wrote several articles about 10 years ago about inappropriate utilization, but it wasn't popular at that time," says Doctor Bree, who is the Blue Cross Blue Shield of Michigan liaison for the Michigan Radiological Society, and member of the MSMS Advisory Committee on Medical Economics and Health Care Delivery. "More was better in a fee-for-service environment."

Doctor Bree adds, "In the managed care environment, we need to know that outcomes we're measuring. For example, in radiology we deal with diagnoses. We may be diagnostically correct 90 percent of the time with a CT scan. But if the problem could have been found 90 percent of the time with a chest x-ray it was not cost-effective."

Doctor Bree is currently doing research using a shared decision making video which allows patients to choose whether they would like to pay extra for non-ionic contrast media when their insurance company would otherwise not cover it. While all of the subjects are given the more expensive media in the end, each is shown a video explaining how doctors decide which type of contrast a patient will receive. The patients are informed of the risk factors and benefits involved, and given an opportunity to select the media they would prefer. Each of three groups is told a

different price that the patient will have to pay if the more expensive media is selected.

"Is society willing to spend money to give everyone better contrast media?" Doctor Bree asks. "Patients just get what they get. Nobody even asks them. Maybe they'd be willing to pay if

they were asked. We need to get the patient involved."

Initiative #2 - Data collection

Richard Ward, MD, MBA, is director of Henry Ford Health Care System's Center for Clinical Effectiveness. The Center is unique in its role of serving the research needs of several hospitals, nursing homes, satellite clinics, an HMO and a group practice of 1,000 physicians.

For outcomes research, the center has developed Flexi-Scan, a software program utilizing scannable paper forms that allows the center to easily create new questionnaires. The Center created the software to utilize a system of medical classifications developed over the past decade by The Health Outcomes Institute, located in Minneapolis, Minnesota. The software codes each response option on questionnaires with internationally standardized codes. "The idea is that, ultimately, many different vendors can all interact together using the same data, regardless of their software," Doctor Ward says.

Doctor Ward adds that the Flexi-Scan program keeps track of logistical information, such as which questionnaire is appropriate for a particular patient, and when the form should be mailed. It can pull address information off the billing system, and even produce stickers for mailing. "We can collect information for about a tenth the cost of most research companies because of the software and the various mechanisms we have for collecting the information," he says.

The Center has also developed the CarePlus

system, an on-line medical record that contains test results, records of visits, dictated charts and other information. The system allows information to be entered from any of Henry Ford Health System's many clinics, hospitals or other sites. Doctor Ward foresees a time when the system will be fully interactive, allowing physicians to immediately access research-based information on the recommended course of treatment for a specific condition.

"The most important barrier to outcomes measurement is the logistics and collection of good data," Doctor Ward says. "There are a lot of health plans that are very loosely assembled that enter into relationships with hundreds of thousands of doctors, that don't invest in outcomes research. They look to outside firms. We can figure things out better because we're all part of the same unit, which allows us to be more tightly coordinated.

Initiative #3 - Shared decision making

Rhoda M. Powsner, MD, JD, MHSA, an MSMS board member and physician consultant with Ford Motor Company, is involved in a shared decision making project. One of Doctor Powsner's projects at Ford involves working with the Greater Detroit Area Health Council, a community service coalition of more than 100 organizations, including business, labor, providers, payers and community agencies, on a video project involving patients with Benign Prosthetic Hyperplasia (BPH).

While an enlarged non-cancerous prostate is a common condition, it often leads to surgery. The condition is not life-threatening, but it may seriously affect patients' quality of life, employment, productivity and health care costs. According to Doctor Powsner, one third of BPH receive "watchful waiting" one third have surgery, and one third get better with no treatment. Patients in the study receive information from the video and are asked to have input into their treatment choices.

Doctor Powsner notes a tremendous variation that has been found to exist in the treatment of BPH in Southeastern Michigan. Three times as many surgeries are performed on the periphery of Detroit, as in the center of the city. Doctor Powsner is intrigued by the prospect of getting first-hand information about the Southeastern Michigan population, as well as on treatment outcomes, without having to rely on insurance companies to provide it.

"If employers are interested in getting some real information on the population without relying on hospital claims data, there's no good measurement.

We don't have data on long-term follow up. People change HMOs every two years. What we really need is good understanding of the clinical course of disease with or without treatment. If you have the data on the disease you can choose a better way to treat.

"How do people respond to the various things we do to them? Information has been based on the Medicare population because they have the data. We're doing this on an employed population in southeast Michigan. There is a genuine desire on the part of the medical community to see what it can do to help industry to delineate costs by getting our hands around what treatments are working.

Doctor Powsner adds, "We need standards, but we need information to make standards."

Initiative #4 - Clinical collaboration

According to Margaret Holmes-Rovner, PhD, chief of the Division of Health Services Research



Continued on following page

Continued from previous page

in the Department of Medicine at Michigan State University, less data is available about the general population than has been accessible about the age 65+ population through Medicare. Her program was established in 1994 to allow researchers in clinical departments more opportunities to collaborate with clinical faculty across larger disciplines. "We can go across the whole spectrum and look at issues that aren't possible for the individual physician to look at," Holmes-Rovner says.

In addition to Holmes-Rovner, a health services researcher, the MSU program is staffed by an epidemiologist, an attorney and a health economist. The Section's main focus is outcomes research. An emerging interest is managed care.

"The original idea of how one should do managed care was that referring physicians should be the gatekeeper, coordinating across the system, recognizing unnecessary care and eliminating it. Ethicists all along have been saying this creates a conflict of interest. More recently, that's become a real issue," Holmes-Rovner says. "We need to rethink the issue of coordination of care -- who is the treating physician and how the patient gets access to all of the aspects of care."

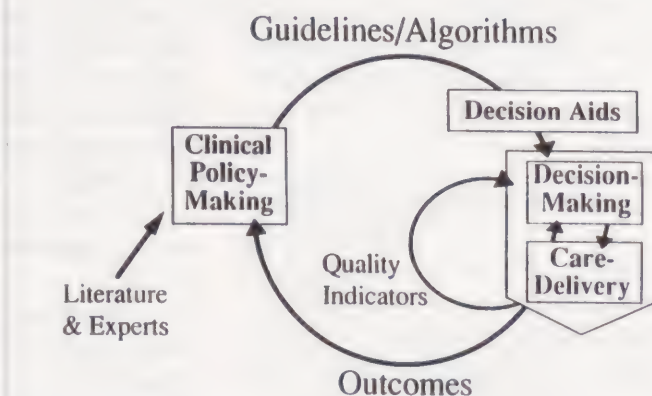
The division's research projects look at the effectiveness of various treatments and procedures in the "real world," Holmes-Rovner says. "There are lots of clinical trials, but we want to look at the real-world application, and work with hospitals on quality improvement issues based on findings."

One of the group's projects is a study of all heart attacks in Flint and Saginaw. More than

1,000 acute myocardial infarctions will be studied by a team of researchers, cardiologists and general internists from Flint, Saginaw and Lansing.

"This is a population-based study in which we want to characterize care of patients and look after one year at morbidity, quality of life, and cost," Holmes-Rovner says. "One piece will be a focus on minority/gender issues, and on the social and economic consequences of heart disease. The next step will be to design quality improvement programs."

Clinical Quality Improvement Cycle



Initiative #5 - Quality improvement

When Jane Deane Clark, PhD, joined the Michigan Peer Review Organization in 1992 to become the executive director of its Center for Health Outcomes and Evaluation, her appointment was the result of a paradigm shift.

"What we had been doing was looking for bad apples," says Clark, whose previous work as senior director of health policy analysis for the Michigan Health & Hospital Association had left her well acquainted with what she describes as "strong antagonisms" between the hospital community and MPRO at that time. "What we're doing now is providing a helping hand."

That shift was documented by Stephen Jencks,

MD, and Gail Wilensky, PhD, in an August 19, 1992 JAMA article, "The Health Care Quality Improvement Initiative." The article described how the Health Care Financing Administration (HCFA) was reshaping its approach to improving care for Medicare beneficiaries, which in Michigan, according to Clark, comprise more than a third of hospital admissions and account for more than 40 percent of hospital revenue. HCFA's new approach was to move its focus from individual clinical errors to helping providers improve the mainstream of care. "Such a reform implies profound changes," the authors wrote. "PROs will use explicit, more nationally uniform criteria to examine patterns of care and patterns of outcomes...focus primarily on persistent differences between the observed and the achievable in both care and outcomes...(and) help providers identify problems and their solutions by monitoring patterns of care and outcomes and allowing providers to conduct the more intrusive and detailed study of who, when, and why."

Clark was hired to create a new division, staffed by researchers, which could provide data feedback to hospitals and propose projects for quality improvement. The division analyzes data, providing hospitals with comparative analyses at six month intervals, and solicits voluntary collaboration from hospitals interested in participating in projects the division proposes. "We're collaborating with hospitals; we're not imposing on them," Clark notes. "We do not tell them what to do. We provide them with data and background information, and they write an improvement plan. The assumption is, this will lead to improved outcomes."

In one such project, 17 hospitals worked with patients suffering chronic atrial fibrillation. According to the literature, Clark says, such patients should be evaluated for risk of bleeding, and if little risk exists, should be anti-coagulated. The division's research has showed that, among the participating hospitals, 42 percent of patients

who could have been appropriately anti-coagulated were. Post-intervention, that number had increased to 62 percent.

In establishing a collaborative environment, Clark notes differing mindsets of those involved. "Physicians normally learn from training that each individual is unique. Their unit of analysis is one. Outcome research stresses our commonality," Clark says. "We analyze with an observation unit large enough to make generalizations," she adds. "What they (physicians) push for is severity adjustment as we go through the process -- and look at each individual as a unique biosystem, when in fact there is a lot of commonality."

To accommodate such diverse perspectives, Clark has established a steering committee that includes representatives from the Michigan Health & Hospital Association, the physician's and nurses associations, and Michigan's medical colleges. The committee approved the division's mission statement, oversees policy, and has the final say on which projects the division should undertake. Once the steering committee backs a project, they look for collaborators. So far, there has been no shortage of takers. Of 162 hospitals in Michigan, 112 are involved in a project of some kind. ■

The author is a Williamston, Michigan-based freelance writer.

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when, in fact,
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World's most popular Internet browser upgraded

Netscape Navigator 2.0 can be easily downloaded

Netscape Communications Corporation released Netscape Navigator 2.0 in early February, marking an important new upgrade to the world's most popular Internet browser. Netscape Navigator 2.0 can be downloaded from the Netscape Internet site <http://home.netscape.com> and is available for all operating systems.

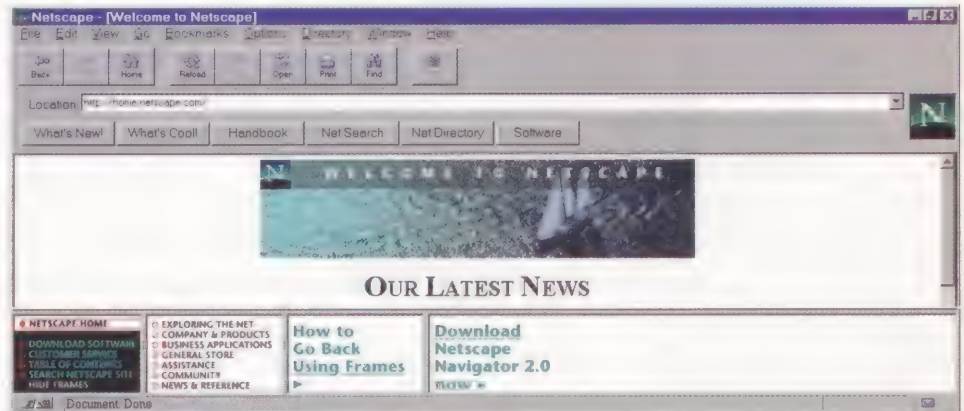
Netscape Navigator 2.0 differs from previous versions of Netscape Navigator in that it includes a complete suite of Internet applications including:

- A World Wide Web browser
- Interactive electronic mail
- Integrated threaded discussion groups.

Netscape Navigator 2.0 also includes new Web browsing features, including support for Live Objects and interactive multimedia content, such as:

- Frames
- Inline plug-ins
- JavaScript
- Java applets
- Embedded spreadsheets
- Animation
- Streaming audio and video
- 3-D capabilities

All of the features listed above will soon be a part of MSMSNET, so we encourage all of our members to upgrade as soon as possible. Netscape Navigator 2.0 software is



The Netscape 2.0 download page. This new form of homepage demonstrates the use of frames and other enhanced World Wide Web features.

free to students and staff of academic institutions and charitable non-profit organizations, and for 90-day evaluation by individuals and commercial users. Others can purchase a retail copy of the software at most software outlets for less than \$50.00. The trial version of Netscape Navigator 2.0 can be found at <http://home.netscape.com/>

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Services, contact Andrew T. Clay at MSMS via E-mail at aclay@msms.org or by phone at (517) 336-7601.

Try MSMSNET free for a month!

Take a free 30-day test drive on the information superhighway with MSMSNET and Voyager Information Network. You'll get a chance to see just how MSMSNET, the physicians' homepage, is geared for doctors, with links to medical research sites and information about physician-specific products and services. To see if MSMSNET and Voyager are right for you, call Andy Clay at MSMS at (517) 336-7601 or Bill DeCourcy at MSMS at (517) 336-7575. Or, you can e-mail them at aclay@msms.org and wdecourcy@msms.org.

Also, if you're currently on the Internet, you can find MSMS at <http://www.msms.org/>.

The MSMS homepage is accessible from any online service. Find us at <http://www.msms.org/>

MSMS studies members

Research reveals intriguing data

How similar are MSMS members to the entire physician population in Michigan? Who are our new members? How well does the House of Delegates represent membership as a whole? We now know the answers to these questions after studying membership data, and the results are quite intriguing.

The primary care/specialty mix is nearly identical between MSMS members and all physicians in the state. Similarly the proportion of physicians by medical school location is very close (44% of MSMS members are from Michigan medical schools, as are 40% of all physicians in Michigan).

Of the nearly 800 new members that joined MSMS during fiscal year 1995, one quarter of them were 30 to 34 years of age. Nearly 20 percent were age 35 to 39. The under age 25 category was 14.6 percent, due in part to a very successful recruitment campaign among medical

students. Forty-five percent of new members were primary care physicians. Internal medicine and family practice accounted for 29 percent of all new members.

One quarter of new members were female physicians. If these patterns hold, MSMS will continue to reflect the demographic trends of the physician population.

The House of Delegates is a remarkably good representative body across several categories. By age, only the 35 to 39 and the 50 to 54 age groups are more than a few percent different when comparing delegates and alternates to all other members in those categories. The distribution of male and female delegates and alternates is nearly identical to that of all other members, and the same holds true for medical school location.

Market Share: Focus of Practice



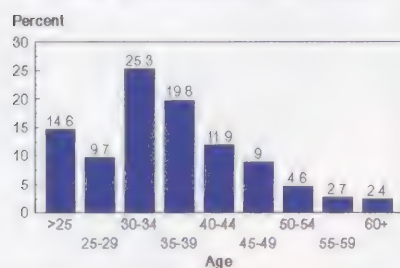
SOURCE: AMA and MSMS Databases

Market Share: Medical School



SOURCE: AMA and MSMS Databases

New Members by Age



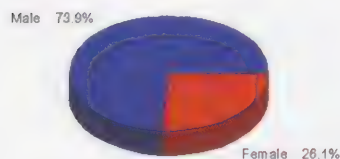
SOURCE: MSMS Membership Database, FY96

New Members by Specialty



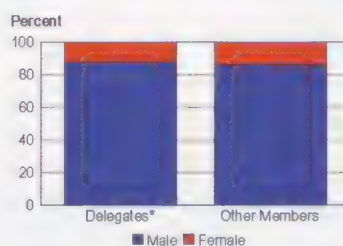
SOURCE: MSMS Membership Database, FY96

New Members by Gender



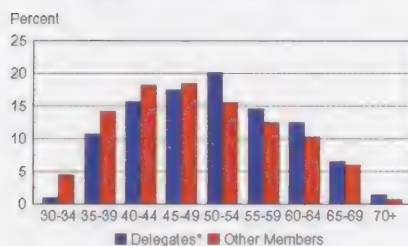
SOURCE: MSMS Membership Database, FY96

House of Delegates Gender Representation



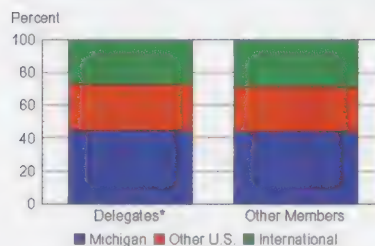
*Includes delegates and alternates
SOURCE: MSMS Membership Database

House of Delegates Age Representation



*Includes delegates and alternates
SOURCE: MSMS Membership Database

House of Delegates Medical School Representation



*Includes delegates and alternates
SOURCE: MSMS Membership Database



ACHIEVING SUCCESS

MSMS PSO: Providing the crucial link

By Kenneth H. Musson, MD

For the past three years, MSMS has engaged in a two-pronged strategy to help its members succeed in the increasingly competitive health care environment. The first part of the strategy has been to educate Michigan physicians concerning managed care and the value of establishing physician organizations. The second part has been to provide consulting services to help physicians establish and operate POs. Through these efforts, MSMS has helped to establish eight POs that include nearly 1,000 Michigan physicians. ►

MSMS Task Force explores alternatives

Approximately one year ago, the MSMS Board of Directors created the Task Force on Physician Networks to explore whether MSMS should create a physician network/HMO or a Physician Services Organization. The Task Force held four meetings and heard presentations by Michigan PO representatives, employer representatives and MSMS legal counsel.

The Task Force carefully studied the alternative of MSMS establishing a statewide physician network or HMO and concluded that it would not be a wise choice for several reasons.

The Task Force believes that **the fundamental problem in establishing a medical society-sponsored network is determining who will be allowed to participate in the network.** A managed care network typically limits its membership to physicians selected on the basis of cost, quality or other factors. Limiting the panel enables the Plan to steer an increased volume of patients to those physicians who meet the network's selection criteria and to have a desirable mix of primary care physicians and specialists. However, while it is not difficult for networks operated by insurance companies or HMOs to exclude physicians, **a medical society-sponsored network that limits membership seriously risks alienating its members who are excluded from the network.** If the network then proves to be successful and takes patients away from the excluded physicians, these physicians may well feel that their medical society has betrayed them.

An alternative to creating a limited physician panel is to allow all medical society mem-

bers to join the network. This would address the membership problem, but would make it extremely difficult for the network to be competitive. This is because the demand for a physician network is likely to come from HMOs and self-insured employers who are interested in contracting with networks that offer significant dis-

counts or risk-sharing arrangements. The Task Force believes it would be difficult for a physician network to offer compensation arrangements that will be attractive to payers unless it can promise increased patient volume to the network's physicians. Moreover, an open panel network also will likely have a problem obtaining an appropriate mix of primary care physicians and specialists.

For these reasons, the Task Force believes that **the problem of determining who will be permitted to participate in the network is an insurmountable barrier to creating an MSMS statewide network or HMO.** In addition to this concern, the Task Force has identified other major obstacles to the formation of a statewide physician network or HMO. First, **employers representatives would likely dismiss the concept of a statewide network or HMO as an effort to preserve the status quo rather than as a serious attempt to address the issues of cost, quality and access.** Second, MSMS Legal Counsel Monte Jahnke, of Kerr, Russell and Weber, warned the Task Force that **establishment of an MSMS-sponsored statewide network likely would raise significant antitrust concerns.** In

How do you feel about the creation of an MSMS PSO?

MSMS values your opinion. Contact Tom Wolff or Mary Anne Ford at MSMS. Tom Wolff may be reached by phone at (517) 336-5740 or via E-mail (twolff@msms.org). Mary Anne Ford may be reached by phone at (517) 336-5721 or via E-mail (maford@msms.org). Send letters to: P.O. Box 950, East Lansing, MI 48826-0950, or by fax at (517) 337-2490.

fact, the AMA's Associate General Counsel informed the Task Force that several state medical society-sponsored networks and HMOs are having antitrust problems, as well as difficulties securing managed care contracts because of skepticism by employers. Third, an MSMS statewide network would compete against physician networks established by MSMS members. Fourth, the Task Force believes that health care is fundamentally a local or regional activity. As a result, the Task Force believes MSMS should assist physicians in forming and operating physician-driven, local networks, rather than establish a statewide physician network or HMO.

Creation of PSO receives strong physician support

At the same time the Task Force was studying the feasibility of a statewide network or HMO, it also closely examined the alternative of establishing an MSMS PSO. A PSO is an entity that provides services to help physician groups and individual physicians manage their practices effectively. It also provides services to help POs and PHOs provide high quality, cost-effective care. The Task Force received input from representatives of several POs who stated that they might be interested in purchasing the following services from an MSMS PSO:

- Credentialing
- Quality assurance/practice guidelines/outcomes/best practices/clinical pathways
- Management information services
- Capitation stop loss and other insurance products
- Assistance in integrating primary care physicians and specialists
- Assistance in formation of group practices
- Networking among POs, i.e., fostering relationships among physician groups
- Assistance in direct contracting with employers
- Developing physician leaders

Based on the views of PO/PHO leaders, the



Task Force believes **there is considerable physician interest in an MSMS PSO**. This entity would provide a physician-controlled and directed alternative to hospital MSOs and for-profit physician management companies (PMCs). Given the rapidly changing health care environment in Michigan and the fact that hospital MSOs and for-profit PMCs are already doing business in the state, the Task Force believes strongly that time is of the essence in establishing an MSMS PSO.

How an MSMS PSO could be created

The Task Force has reviewed the following

Continued on following page

Continued from previous page

options for capitalizing an MSMS PSO:

A PSO that is capitalized and owned by individual physicians who purchase stock in a separate MSMS PSO entity. This approach would require a one-time financial commitment (e.g., \$1,000) and perhaps an annual fee (e.g., \$250). Although this approach would provide a greater sense of member "buy-in" than some other approaches, it could prove limited as a source of needed start-up capital and would not take advantage of opportunities to obtain capital from the public markets.

A PSO created through a joint venture between MSMS and an academic institution, physician management company or other entities. Under this approach, MSMS might serve as a subcontractor to perform certain PSO functions, such as credentialing and quality management. This approach would allow MSMS to build upon the expertise of an existing entity and offer a range of sophisticated PSO services more quickly than if it chose to build a PSO "from the ground up." It may be difficult, however, to find a credible, compatible business entity which understands the nuances of a medical society and its members.

A PSO created through a joint venture with a major Michigan insurance company. Although this approach would provide perhaps the greatest potential for access to covered lives and managed care contracts, there could be philosophical and business differences between MSMS and insurers which might make this option difficult to achieve.

A PSO formed as a combination of the other

options may be feasible. For example, a PSO could be owned jointly by MSMS, individual physicians and another entity (e.g., insurance company, academic institution or physician management company).

No decision has been reached as of yet, but the Task Force believes that it is essential that physicians retain majority ownership of the PSO and that a more thorough exploration and evaluation of the above options and others is warranted. To this end, the following initiatives are now underway:

- Focus groups and other market research designed to assess interest and demand among Michigan physicians for obtaining services from an MSMS PSO.
- Market research to determine whether physicians are interested in investing money in an MSMS PSO, and, if so, how much money they would be willing to invest.
- Site visits to successful PSOs developed by medical societies, hospitals, for-profit companies and POs to determine key PSO success factors.
- Discussion with other organizations of potential PSO partnerships.
- Analysis by MSMS legal counsel of the major legal issues involved in forming a PSO.

The issue of whether MSMS should form a PSO will be addressed at the 1996 MSMS House of Delegates meeting on April 26-28 in Dearborn.

Watch *Medigram* and *Michigan Medicine* for further details and updates. ■

The author is chair of the MSMS Task Force on Physician Networks.

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Thomas L. Haynes, MD

Making a small dent in the big problem of addiction

By Karen Bouffard

When Thomas L. Haynes, MD, found himself in treatment at The Hazelden Foundation, an addiction treatment center in Center City, Minnesota, he was just 30, and two years into a career in emergency medicine at an Akron, Ohio, hospital. It was 1979.

may be their drug of choice."

"These are people who've had a hard time getting sober and clean with traditional models of treatment," he adds. "They have a lot to lose, such as a livelihood, if they don't build a solid recovery."

"Physicians are not special people, but they have special issues...they have constant access to, and contact with, mood altering chemicals — any of which may be their drug of choice."

"Three things prompted me to seek treatment," he says. "My psychiatrist, my lawyer, and the Medical Board of Ohio."

As Doctor Haynes puts it, that treatment "was not immediately successful. I had more learning to do." After succeeding in his recovery for nine months, Doctor Haynes won back his medical license. One year later, he relapsed.

"That's what sent me down to The Talbott Program," he says, calling the Atlanta, Georgia-based addiction treatment program "the premier treatment program in the world for physicians." He adds, "I knew I had no more chances to recover, so when I got there I was very willing to follow the directions I was given." At Talbott, Doctor Haynes found the kind of special care that he, as a physician, needed. As a result, he was able to build a successful recovery, and later became founding president of the Michigan Society of Addiction Medicine, a chapter of the American Society of Addiction Medicine.

Today, Doctor Haynes is president and medical director of West Michigan Addiction Consultants, PC (WeMAC) in Grand Rapids, a 28-bed residential and outpatient treatment center based on the Talbott model. The program is designed to meet the needs of medical and legal professionals, and other "hard-to-reach" addicted people, through a four-month treatment program offering a group and individual therapy approach.

"Physicians are not special people, but they have special issues," Doctor Haynes says. "They have to be licensed, and by the nature of their work, they have constant access to, and contact with, mood altering chemicals -- any of which

Lack of preparation

In retrospect, Doctor Haynes believes he suffered from the disease of addiction throughout college, but it had not reached recognizable proportions. A native of Beulah, located in the northwest lower peninsula near Traverse City, Doctor Haynes graduated from the University of Michigan Medical School in 1974. But his medical school education did not prepare him to recognize or seek treatment for the disease.

"Medical schools have traditionally done a lousy job of teaching about this disease. That's beginning to change, but it's changing very

Impaired Physicians: Where to go for help

Physicians suffering from, or suspecting, problems with addiction or substance abuse can contact the following for assistance:

MSMS Physicians Recovery Network

Douglas Macdonald, MD
(810) 391-4742

Health Professional Recovery Program - State of Michigan

Lee Young, RN, ACSW
1-800-253-7700

International Doctors in Alcoholics Anonymous

C. Richard McKinley, MD
P.O. Box 199
Augusta, Missouri 63332
(314) 482-4548

slowly," he says, adding he believes medical colleges should require a ten-hour addiction medicine curriculum spread over the first two years. He also recommends attendance at open Alcoholics Anonymous or Narcotics Anonymous meetings as part of a mandatory addiction medicine rotation. "When I first went into treatment, I knew nothing about addiction, even though I had gone to medical school.

"Because of a general lack of knowledge, the people in charge of me made a lot of mistakes," he says of his early treatment experiences. "For instance, sending me to individual therapy, rather than to treatment. Individual therapy was beneficial, but not adequate to deal with the addiction."

He adds, "In one-on-one treatment the addict always wins. We are cunning, manipulative and in denial -- all of the usual defenses the addict uses."

According to Doctor Haynes, there are many resources available to deal with the unique needs of impaired physicians (see sidebar.) The Physicians Recovery Network is a program run by MSMS together with the Michigan Association of Osteopathic Physicians and Surgeons. The Network operates under the oversight of the MSMS Committee to Assist Impaired Physicians, of which Doctor Haynes has been a member since 1985.

The Committee was also instrumental in creation of the Health Professional Recovery Program, which was approved by the State Legislature in 1993, and fully implemented in the summer of 1995. Doctor Haynes chairs the Health Professional Recovery Committee composed of 15 representatives of the various health professions, that oversees the program.

The program allows physicians who are impaired by addiction, substance abuse or mental illness, an opportunity to build their own recoveries without discipline. Participants are voluntarily monitored for three years, followed by a five-year recovery period. If, after five years, they are successful in recovery, their record is expunged without their ever having come to the attention of the Board.

A difficult road back

For Doctor Haynes, as for all recovering physicians, returning to medicine was not easy. After treatment, he returned to Ohio, and practiced emergency medicine at a Cleveland hospital for three more years. He got lucky, he

says. "I got the job because the director had a heart attack, and they needed somebody, anybody, real badly."

In 1985, after cleaning up his problems with the Ohio Board of Medicine, and obtaining a license in Michigan, he moved back to his home state to begin a full-time practice in addiction medicine.

Through it all was his wife Gail, whom he'd



met as an undergraduate student while working in Yosemite Valley, Yosemite National Park, California. The two married in a romantic ceremony in the park in 1971, and went on to give their three sons names associated with Yosemite: Lyell, 21 a junior in computer engineering at the University of Michigan, and Dana, 18, a senior at East Grand Rapids High School, are named after the two highest mountains in the park; 16-year-old Galen Clark, a tenth-grader at the high school, is named after the park's first guardian. Gail is now a certified social worker and vice president of WeMAC, in charge of running the Center's children's programs.

"We're just making a small dent," Doctor Haynes says. "This is such a pervasive problem."

■ *The author is a Williamston, Michigan-based freelance writer.*

James E. McGillicuddy, MD

A leader for Michigan physicians

By William Kendy

James E. McGillicuddy, MD, the new chief of staff of Lansing's Sparrow Hospital, has come full circle. His family has deep roots in both the Lansing area and the Lansing medical community. In fact, Doctor McGillicuddy's grandfather was one of Sparrow Hospital's founding fathers.

"They researched the history of Sparrow and found that there was a Doctor McGillicuddy involved, around the turn of the century, in the formation of the hospital," says Doctor McGillicuddy. "And sure enough, he was my grandfather."

As far as Doctor McGillicuddy is concerned, practicing medicine was a lifelong dream. "I really never considered any other career," he says. "It's in the genes."

But the road to becoming a doctor was not an easy one. In his first rotation in medical school, Doctor McGillicuddy was assigned to psychiatry, which for him was a thoroughly unpleasant experience.

"To say that the department and I didn't hit it off would be like saying that Walt Disney and Adolph Hitler would be close friends," says Doctor McGillicuddy. "They tried to fail me...only my testing eliminated me from dropping out of medical school."

Doctor McGillicuddy found his calling with his next rotation -- surgery. "It was love at first midnight call," he says.

After a two-year stint in the Air Force, Doctor McGillicuddy served a residency at the University of Cincinnati. In 1973, he moved to Lansing and joined two other general thoracic surgeons. In 1990, one doctor retired and the other relocated, leaving Doctor McGillicuddy by himself. That's when he decided to start his own practice, the Lansing Hernia Center.

"I was left alone in a larger corporation and I could see no benefit from the rather stiff overhead," he says. "Plus I had a sneaking feeling

that I would love the business of medicine. And it all turned out to be true."

Changing gears

In preparation for his new responsibilities as chief of staff at Sparrow, Doctor McGillicuddy deliberately started to reduce his

work load at the clinic.

"I've wound down my practice to accommodate these new responsibilities," says Doctor McGillicuddy. "I realize that there will be a lot of time commitment and I'm hoping that there will be a meld between their interests and my needs."

Doctor McGillicuddy believes strongly in the concept of competition and supply and demand economics when it comes to the business of hospitals and medicine.

"I believe that Lansing should have variation of choice," he says. "Competition is, in fact, a good thing. There should be two strong health care systems in Lansing, and Sparrow should be one of them. From a physician's standpoint, competition is healthy. As long as there are other options, there is no danger to the community, only healthy competition. It's the market working in its fullest degree to support the consumer."

According to Doctor McGillicuddy, there is room for improvement in the Sparrow Hospital system, especially in terms of outpatient care and efficiency.

"Sparrow is not set up for out-patient facilities," he says. "It has the same drawbacks as all other hospitals that were built before 1990. It was built to orbit around the in-patient and that's not going to be the future of medicine. We need to move toward becoming a home care, out-patient, ambulatory based services organization. Sparrow needs to get its management and physical plant in order for that to be accomplished."

Doctor McGillicuddy did not feel it was out of the realm of possibility for Lansing to become

a one hospital town.

"It's not an unlikely scenario...I hope not, but it's very possible," he says. "For the last four to five years, everybody has been talking, dickering and maneuvering, and now with Columbia HCA a player (maybe), it will be even more fascinating to see who takes who to the altar."

Communication key

One of Doctor McGillicuddy's main goals as chief of staff at Sparrow Hospital is to make sure the lines of communication are open between himself and the hospital's medical staff.

"I want to try to get the best perspective on the changes that are happening in medicine, so that I can best represent the Sparrow physicians.

When Doctor McGillicuddy isn't practicing medicine, he is an avid sports enthusiast, who enjoys sailing, skiing, flying and tennis.

"I'm a fair weather sports enthusiast," says Doctor McGillicuddy. "I'm not a hard core, push the envelope type of guy. When the weather is nice, that's when I like to play. And Michigan offers a ton of different sports opportunities." ■

The author is a Holt, Michigan-based freelance writer.



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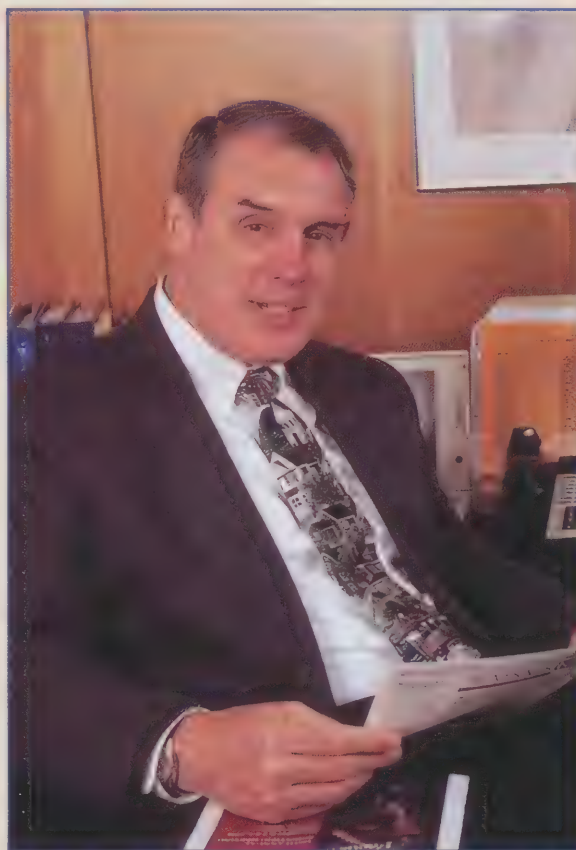
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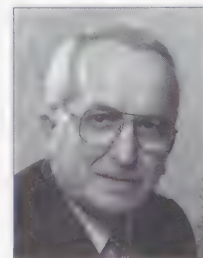
Medicare:

Number 3



This is the third in a series of monthly articles that examine aspects of Medicare. This month we present an overview of Medicare supplemental (Medigap) insurance policies. In the future, we will delve into Medicare, Medigap, and employer-sponsored private insurance options for physicians and their employees who continue to work after turning age 65.

—Earl G. Moehn, MD, Chair
MSMS Group Insurance Trust



Critical Analysis

Navigating the Medigap Maze, Part I

Many physicians in office practice provide health insurance to themselves and their spouses as well as to their employees and spouses. As the physicians and their employees approach age 65, they should consider their future health insurance needs in relation to Medicare. It may be wise to enroll in Medicare and also obtain Medicare supplemental health insurance.

What Do Medigap Policies Cover?

As their name suggests, Medigap policies are designed to fill specific gaps in benefits, deductibles, and copayments that Medicare does not cover. Almost 70 percent of Medicare beneficiaries also have Medigap insurance. In 1992 these policies became strictly regulated by state and federal government. In Michigan and in most other states, ten standard policies may be sold as Medicare supplement insurance. These plans--which are designed A through J -- offer the same benefits regardless of which private insurer sells them. Insurers also are permitted to sell plans that offer more benefits than the J plan, the "richest" of the Medigap offerings. The Michigan State Medical Society offers two such plans through Blue Cross and Blue Shield.

Medigap Plan A is the basic policy. Its most important benefit is that it covers the Medicare Part A deductible of \$716 and copayment (\$179 a day) for the 61st through 90th day of hospitalization in each Medicare benefit period; after all Medicare hospital benefits are exhausted, it then covers 100 percent of Medicare A eligible hospital expenses. Plan A pays the coinsurance for Part B services--usually 20 percent of the approved amount of services--after the annual \$100 deductible is met. Plans B through J cover all the benefits in the basic policy plus combinations of new benefits such as the Part A deductible, daily copayment for skilled nursing care, preventive care, and, in plans H and J, prescription drugs. Even the most comprehensive Medigap plans do not cover all health care expenses, however, and this is especially true for long-term care and prescription drugs.

Many seniors purchase the "richer" Medigap policies because they offer prescription drug coverage, yet even these do not pay all costs. Plans H and I cover half the cost of prescription drugs, up to an annual benefit of \$1,250 after the policyholder meets a \$250 per year deductible; Plan J covers up to \$3,000 a year, after the \$250 deductible is met.

MSMS's Medigap Offerings

The two MSMS Medigap plans offer benefits over and beyond Plan J, and they are available to physicians, their spouses, and their employees at age 65. The first is an "exact fill" policy -- that is,

(continued on following page)



Michigan State Medical Society
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when combined with Medicare, it offers a level of coverage equivalent to a comprehensive employer health care plan. It covers 100 percent of all Medicare Part A deductibles and copayments and all copayments for Part B. In other words, the policyholder does not pay, for example, the \$716 Part A deductible for hospitalization. It also has unlimited prescription drug coverage, with a choice of (1) a \$150 annual deductible (\$300 for the family) or (2) a \$10 copayment per prescription. Under the first, the policyholder pays 20 percent of the prescription cost, once the deductible is met.

The other MSMS Medigap option is "Master Medical 65." Like the exact fill option, this covers all Medicare Part A deductibles and copayments. With Part B, the policyholder is responsible for 20 percent coinsurance on most services, but the plan will reimburse 80 percent of the 20 percent coinsurance, limited covered services. The prescription drug coverage under this option is unlimited and has a \$10 per prescription copayment.

MSMS's unique relationship with Blue Cross and Blue Shield of Michigan allows for spousal continuation of Medigap insurance. If an MSMS member dies while insured with a MSMS endorsed plan, his/her spouse and family can retain coverage as long as the premiums are paid and they maintain residence in Michigan or live in Michigan at least six months of the year.

What Factors Figure in the Cost of Medigap Policies?

All Medigap insurers must use the same format, language, and definitions in describing their policy offerings. The insurer's products are alike, so they compete on service, reliability, and price. And insurers do charge different premiums for the identical sets of benefits. In addition to geographical variations in rates--a result of differences in the costs of providing services from one region to another--insurance companies use three age-based methods for determining premiums: issue age, attained age, and no age.

Under the issue age method, if at age 65 you buy and are issued Medigap policy, in subsequent years you still will be charged only what the insurer currently is charging 65-year-olds, regardless of your own age. This does not mean, however, that your policy always will cost the same; the premium likely will go up over the years. With the attained age method, the monthly premium is based on your current age, not on the age at which you bought the policy. If your insurer uses no age rating, everyone pays the same premium, regardless of age. The two MSMS Medigap plans do not rate on the basis of age or gender. As mentioned, premiums do vary some by geography, however.

Medigap insurers may impose preexisting-condition restrictions for a maximum of six months. Preexisting health problems generally are defined as those about which one has seen a doctor in the six months before the policy went into effect. MSMS's two Medigap options do not have preexisting condition clauses.

Conclusion

As physicians, their spouses, and their employees near age 65, they need to think long and hard about their health care needs. The fact that 70 percent of Medicare beneficiaries also have Medicare supplemental health insurance is testament to the importance of supplemental coverage. When deciding upon the best policy, we must recognize that we may require more health care than we needed in the past. After all, the reason most of us carry insurance is because it is so difficult to anticipate those future needs. ■

In these changing times it's important to plan ahead. MSMS Group Insurance Trust representatives will be glad to discuss protection for your future, your finances and your family:

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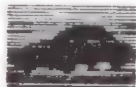
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Rabies

New Threats Loom in Michigan

By Paul C. Bartlett, MPH, DVM, James Sikarskie, DVM and Mary Grace Stobierski, DVM, MPH

Until recently, Michigan has been spared major rabies epidemics caused by terrestrial (land) rabies reservoirs such as skunks, fox, raccoons, coyotes, and our domestic mammals. Several new developments in rabies epidemiology threaten to dramatically, and perhaps permanently, change the character of rabies within our state.

Our state's departments of agriculture, natural resources and public health may soon need to decide if the current technology, resources, economics, and political climate warrant active control and prevention of rabies in our wildlife populations.

Current threats

The most immediate rabies threat in Michigan involves the ongoing outbreak of **coyote/dog rabies** along the Texas-Mexican border. This outbreak involves a particular strain of rabies virus which is adapted for transmission in coyotes and dogs, and does not currently exist in Michigan. Farm laborers from this border region often bring their pets with them to Michigan for the summer, providing an opportunity for this strain of rabies to become established in our wild and domestic canid population. Michigan governmental agencies are trying to prevent this virus from being brought to Michigan.

The second most immediate threat relates to the **raccoon strain** which is slowly moving west from New York, Pennsylvania, and West Virginia. If the raccoon rabies spreads across Ohio and approaches Michigan's southern border, we must make a difficult decision to either allow the rabies outbreak to enter our state unabated, or attempt to prevent

the epidemic from entering Michigan's borders. At current rates of spread, it could take eight-to-ten years for the advancing epidemic to reach Michigan after entering Ohio.

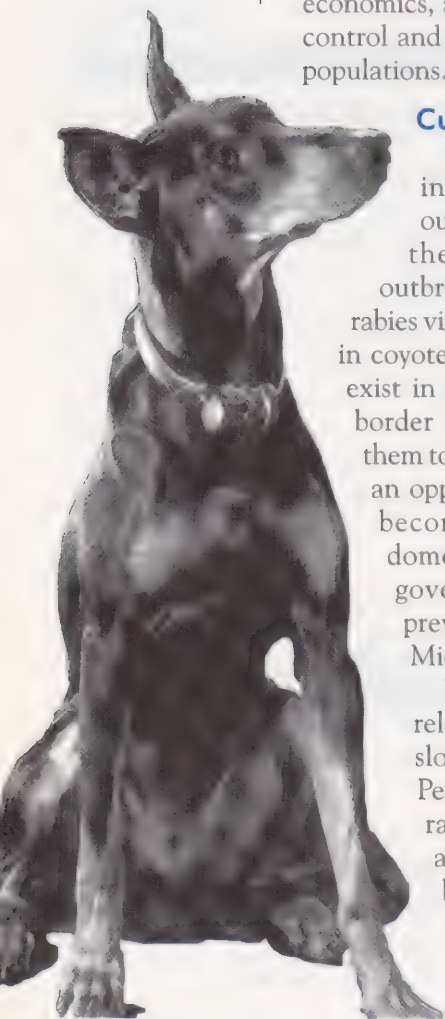
A third threat relates to yet another strain of the rabies virus which is adapted for transmission in the fox population. Many

areas of Ontario have endemic **fox rabies** with this strain, and although the Canadians have been very successful in controlling the disease, it is always possible that a nidus fox rabies infection could become established adjacent to Ontario's borders which sometimes can be transversed by migrating fox during the cold winter months when surface waters are frozen.

The **northern skunk-strain of rabies**, which is endemic to the Northern Midwest, represents an additional rabies threat to Michigan. Skunk rabies has shown no sign of moving into Michigan, although we certainly have a sufficiently dense skunk population to support endemic skunk rabies should this strain be introduced by human-assisted movement of infected skunks.

New oral vaccine

In the past, governmental agencies were limited to tracking and monitoring approaching animal rabies epidemics to warn health care workers and animal control personnel; effective wildlife disease control procedures were not available. In 1995, a new wildlife rabies vaccine was licensed, compelling rabies control personnel to re-evaluate the possibility that the control of wildlife rabies might be cost-effective and in the best interest of the state's public health. Other countries and several eastern US states are currently experimenting with oral wildlife vaccination, and these vaccination trials should eventually provide useful technical and procedural guidance for formulation of a cohesive



statewide rabies control policy.

In writing this article, we do not advocate control of rabies in Michigan with oral vaccination, but rather seek to open discussion among involved governmental agencies, private organizations, interested citizens, and health professionals.

Control options

The advent of the new oral rabies vaccine for wildlife and our fortuitous circumstance of being protected on the east and west by the Great Lakes provides Michigan with an opportunity to prevent entry of the raccoon rabies outbreak. Two disease control components would be required: an immune barrier across the southern border with Ohio and Indiana, and an established outbreak control team capable of strengthening breaks through the barrier or quickly extinguishing isolated rabies outbreaks throughout the state by ring vaccination (vaccination within a circle surrounding the outbreak).

Economic impact

A New York study conducted prior to the advancing raccoon rabies epidemic showed a per capita expenditure increase of \$5.73 (\$4.06 to \$9.79) after raccoon rabies entered two counties. For Michigan's 9.3 million people, this would amount to \$53 million per year, indicating that, economically, controlling raccoon rabies is at least worthy of consideration. Cost components in this study included increased animal rabies diagnosis, human post-exposure rabies prophylaxis, rabies consultations, vaccination of pets, and quarantine of exposed animals.

Ontario rabies control authorities have long been convinced that control of rabies in foxes is economical, with estimates of direct rabies costs of \$1.6 million and indirect costs of \$2.4 million. A cost-benefit analysis in two New Jersey counties showed that oral vaccination of wildlife was cost-effective. Had New Jersey created a successful immune barrier zone along its border with Pennsylvania and New York, it would have saved an estimated \$45 million.

An immune barrier across the southern row of Michigan counties would cost approximately \$1.2 million per application. There is currently debate regarding whether one or two applications per year would be needed. Program costs are especially difficult to estimate because many of the previous vaccination trials in the East and

large research components which would not be required by the time raccoon rabies reached Michigan borders. Based on the costs of other vaccination programs, yearly program costs could be estimated at between \$3 million and \$10 million.

Arguments for control

Creation of immune barriers would expectedly be the most cost-effective usage of oral wildlife vaccination. In Michigan, the Great Lakes act as effective natural barriers to spread; an immune barrier across the southern row of counties would protect 15 square miles of Michigan for every square mile within the immune barrier.

Oral rabies vaccination of wildlife is more "environmentally friendly" and humane than are trapping, hunting, bounties and other largely ineffective control methods which would undoubtedly be instituted upon arrival of terrestrial rabies in Michigan. Maintaining Michigan free of terrestrial-strain rabies could be an advantage for Michigan hunting and outdoor tourism, especially if the rest of the Midwest were endemic for wildlife rabies. Raccoon and skunk rabies have taken considerable toll on livestock in the eastern outbreak, so our state's agricultural industry may support wildlife rabies control.

The public health rationale for rabies control is difficult to assess. At least two human cases have been associated with the dog/coyote strain in Texas. To date, no human cases of rabies have been reported associated with the eastern raccoon-strain outbreak. Some would explain this perfect record by the excellent rabies control efforts instituted, and the large number of persons receiving rabies post-exposure immunization. It is also possible that raccoon-strain rabies has a relatively low zoonotic potential. Regardless, rabies must always be considered a zoonotic disease of public health importance. The greatest health impact in the East has been in the explosion of post-exposure rabies prophylaxis, at approximately \$1,500 to \$5,000 per person.

Administrative threats

Keeping Michigan free of terrestrial rabies would require a consistent yearly effort, which can be a difficult task for governmental agencies. Temporary budget cuts and hiring freezes could allow rabies to move into the state and nullify the efforts of previous years. A 99 percent leak-proof barrier is useless. We either play the game

Continued on following page

Continued from previous page

to win, or we should not play.

Michigan needs to carefully monitor and learn from the legislative and law enforcement experiences of other states which are experimenting with oral vaccination. Some legislative changes may be reached regarding vaccination on private lands. Laws regarding inter-state and intra-state movement of wildlife would need to be toughened or more strictly enforced. Banning the live trapping and translocation of nuisance wildlife and rehabilitation and relocation of wildlife would be necessary. Law enforcement officials and prosecutors would need to make rabies control a priority, and this could be difficult if enforcement of rabies laws are seen as secondary to other activities. Oral vaccination in Michigan should not be attempted without firm and complete legislative and law enforcement support.

Cooperation would be required among many agencies: the Michigan Department of Agriculture, the Michigan Department of Public

Health, local health departments, the Michigan Department of Natural Resources, academic institutions, animal control offices, and others. Establishment of a Michigan wildlife rabies task force would be advisable.

The default decision to let terrestrial wildlife rabies enter Michigan unabated may or may not be the best decision for Michigan. If we decide against controlling wildlife rabies, we should do so with knowledge, foresight and a full understanding of the alternatives. Once terrestrial wildlife rabies become endemic in Michigan, future eradication efforts would be nearly impossible. Attempting control with a preconceived plan with interagency policies and procedures would help facilitate successful control of a rabies epidemic. ■

Doctors Bartlett and Sikarskie are on staff at the MSU College of Veterinary Medicine. Doctor Sobierski is employed by the Michigan Department of Public Health.

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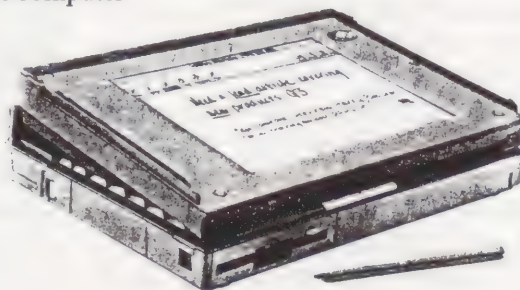
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Newsmakers

George H. Shade, MD, chief of obstetrics and gynecology at Detroit Riverview Hospital, is a newly-elected member of the Detroit-Macomb Hospital Corporation's Board of Directors. He will serve a three-year term as a medical representative. Re-elected to the Board are: **Frank Clark, DO**, chief of family practice at Detroit Riverview Hospital; and **William Bonnefil, MD**, from the obstetrics and gynecology department at Macomb Hospital Center.

Ross D. Zafonte, DO, medical director of the Trauma Brain Injury Unit at Rehabilitation Institute of Michigan (RIM), has been selected by his peers to be included in the first edition of *The Best Doctors in America: Midwest Region* (1996-97).

Howard A. Brody, MD, a Michigan State University professor of family practice and director of the MSU Center for Ethics and Humanities in the Life Sciences, is a newly-elected member of the Institute of Medicine, an honor society affiliated with the National Academy of Sciences. Doctor Brody is chair of the MSMS Committee on Bioethics as well as the Michigan Death and Dying Commission.



Howard A. Brody, MD

Alan Mindlin, MD, is the new chief of staff at North Oakland Medical Centers. A board certified ophthalmologist, Doctor Mindlin has served the hospital in various capacities during his 30 years in practice. **Eliezer Basse, MD**, chair of the Department of Emergency Medicine at North Oakland Medical Centers, is the new chief of staff-elect.



Ian T. Jackson, MD, chair of plastic surgery at Providence Hospital, has been awarded the Sir Harold Gillies Gold Medal by the British Association of Plastic Surgeons. Doctor Jackson gave the Bi-annual Gillies Memorial Lecture to the Association at the Royal College of Surgeons in London on November 30, 1995. The lecture was entitled, "Contributions of Plastic Surgery to Skull Base Surgery." He is the second American plastic surgeon to receive this honor.

Marigowda Nagaraju, MD, a Flint internist, will receive the Clem Alfred Humanitarian Award in late March from the Community Foundation of Greater Flint. The award recognizes Doctor Nagaraju for his seminal work in the creation of the Genesee County Free Medical Clinic. Founded in 1991, the Free Clinic handles approximately 150 patients per month. ■

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Mutee Abdeljaber, MD, Sandusky

Rownak Ahmed, MD, Detroit

Adam B. Blickley, MD, Grand Rapids

Craig W. Bohnhoff, MD, Saginaw

Dwayne L. Cook, Grass Lake

Timothy C. Cox, MD, Port Huron

Kenneth Elmassian, DO, East Lansing

Faris Fadheel, MD, Detroit

Roger K. Gerstle, MD, Acme

Juliana J. Grey, MD, Grand Rapids

Brian S. Hartfelder, MD, Saginaw

Karma K. Hayes, Lansing

Michelle Henderson, MD, Flint

Tina M. Hendrix, MD, Flint

John W. Jones, MD, Jackson

John F. Keller, MD, Grand Rapids

Hanif Khan, MD, Detroit

Steven J. Kin, DO, Madison Heights

Jeffrey J. Kirouac, MD, Commerce

Steven F. Kokmeyer, MD,
Kalamazoo

John Kolstoe, MD, *East Lansing*

Geoffrey D. Kusch, MD, *Midland*

Robert T. Malinowski, MD,
Dearborn Heights

Shari L. Maxwell, MD, *Detroit*

James T. McLaren, MD, *Kalamazoo*

Paul A. Meyer, MD, *Saginaw*

Jasjeet K. Miglani, MD, *Detroit*

Edward M. Millermaier, MD,
Kalamazoo

Donald R. Moore, MD, *Grosse Pte*
Woods

Maurice J. Norman, MD, *Grand*
Rapids

Gregory P. Nowinski, MD, *Troy*

Amy D. Osborn, *East Lansing*

Vivekanand Palavali, MD, *Flint*

Harshad P. Patel, MD, *Jackson*

Dianne Plath, MD, *Detroit*

Matt Ptazkiewicz, *East Lansing*

Rose M. Ramirez, MD, *Grand*
Rapids

Peter M. Ranta, *East Lansing*

Harun Rashid, MD, *Detroit*

Stephen B. Reznicek, MD, *Cadillac*

Donald M. Rochen, DO, *Madison*
Heights

Julie L. Sanford, MD, *Nazareth*

Leonard B. Savoy, MD, *Bloomfield*
Hills

Keith E. Scharf, MD, *Saginaw*

Andrew J. Seiwert, MD, *Holland*

Robert M. Soltysiak, DO, *Grand*
Rapids

Michael A. Spencer, MD, *Wyoming*

David P. Steinberg, MD, *Ypsilanti*

Jeffrey S. Stern, DO, *Kalamazoo*

John G. Suelzer, MD, *Leland*

Christopher S. Sweet, MD,
Clarkston

Nikolay Z. Tchopov, MD, *Grand*
Blanc

Michelle Verplanck, DO, *East*
Lansing

Federico C. Vinas, MD, *Detroit*

Aparna Vuppala, MD, *Detroit*

Todd J. White, DO, *Kalamazoo*

George Wilson, Jr., MD, *Detroit*

Nathaniel R. Woodruff, MD,
Midland

James O. Wooliscroft, MD, *Ann*
Arbor

Matthew M. Yeomans, MD, *East*
Lansing ■

Deaths

Richard W. Pomeroy, MD, an East Lansing orthopedic surgeon, died January 30 at the age of 81. A 1941 graduate of the University of Michigan Medical School, Doctor Pomeroy was a member of and served on numerous committees for the American Medical Association, the Michigan State Medical Society, the Ingham County Medical

Society, the Michigan Orthopedic Society, Detroit Academy of Orthopedic Surgeons, Association for Crippled Children and Adults, United Cerebral Palsy of Michigan and the American Academy of Orthopedic Surgeons.

Duane E. Smith, MD, a Brown City general practitioner, died January 5. He was 73. A 1952 graduate of the Wayne State University School of Medicine, Doctor Smith practiced medicine in Brown City for over 40 years. He was a member of the American Board of Family Practice and was instrumental in the growth of Marlette Hospital, including initiating the Hospice program. He had been a faculty member of the Wayne State University School of Medicine and was a member of MSMS and the Sanilac County Medical Society. He was past mayor of Brown City and served on the City Council.

Ralph Worthington, MD, a Lansing general surgeon, died November 11, 1995. He was 79. A 1942 graduate of the Wayne State University School of Medicine, Doctor Worthington a member of the Ingham County Medical Society and MSMS. ■

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Camran G. Adly, MD, 3008 W. Pinhook Rd., Lafayette, LA 70508
Action, Date Taken: License Revoked, Fine - \$1,000.00, 01-12-96
Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Jonathan A. Agbebiyi, MD, P.O. Box 181135, Corpus Christi, TX 78480
Action, Date Taken: License Revoked, Fine - \$1,000.00, 01-12-96
Reason: Negligence/Incompetence

Name: Zack B. Brown, MD, 14438 W. Nichols, Detroit, MI 48235
Action, Date Taken: License Suspended - 6 mo., Fine - \$20,000.00, Probation - 3 yrs., 01-12-96
Reason: Criminal Conviction - Drug Related

Name: Robert L. Camp, MD, 137 Benzie Blvd., Beulah, MI 49617
Action, Date Taken: Summary Suspension Dissolved, 01/02/96
Reason: None Given

Name: Joel H. Mayer, MD, 714 White Spar Rd., Lot 9, Prescott, AZ 86303
Action, Date Taken: License Revoked, Fine - \$1,000.00, 01-12-96
Reason: Probation Violation

Name: Atiya Murtuza, MD, 4524 Kevin Court, West Bloomfield, MI 48322
Action, Date Taken: Reinstated w/Limited License, 12-13-95
Reason: None available

Name: David J. Smith, MD, 11615 S. Hartel, Ste. 206, Grand Ledge, MI 48837
Action, Date Taken: Probation - 2 yrs., Fine - \$10,000.00, 01-12-96
Reason: Negligence

Name: Nicholas N. Velarde, MD, 1335 S. Linden Rd., Ste D., Flint, MI 48532
Action, Date Taken: Limited License, Probation - 2 yrs., Fine - \$1,000.00, 12-13-95
Reason: Mental/Physical Inability to Practice ■

MSMS Meetings

March

27, Making the Rounds. Location: St. Luke's Hospital, Saginaw, MI. Contact: F. B. "Tom" Plasman at MSMS at (517) 336-5724.

28, Maternal & Perinatal Health Conference. Location: MSU Management Education Center, Troy, MI. Contact: Sarah Cressman at MSMS at (517) 336-5727.

April

11-12, Master Series Conference on Managed Care. Location: The Stouffer Hotel, Battle Creek, MI. Contact: Ginger Marenich at MSMS at (517) 336-7600.

18, Making the Rounds. Location: Borgess Medical Center, Kalamazoo, MI. Contact: F. B. "Tom" Plasman at MSMS at (517) 336-5724.

18-19, Michigan Medical Group Managers Meeting. Location: Lansing. Contact: Andrew Lott at (517) 336-7589.

26, MSMS Regional Scientific Meeting. Location: Dearborn. Contact: Sarah Cressman at MSMS at (517) 336-5727.

26-28, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Donna Brown at (517) 336-5735 or Jeanne Miller at (517) 336-5726.

26, 28, MSMS Board of Directors Meeting. Location: Ritz

Carlton Hotel, Dearborn. Contact: William E. Madigan, Executive Director, at (517) 336-5734.

29-May 1, MSMS Alliance House of Delegates Meeting. Location: Park Place, Traverse City, MI. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

May

15, Rural Communities and HIV/AIDS. Location: Grand Traverse Resort, Traverse City, MI. Contact: Tom Seely at MSMS at (517) 336-5770.

20, Health Education Foundation Fourth Annual Golf Classic. Location: Country Club of Lansing, Lansing, MI. Contact: Dawn Reha at MSMS at (517) 336-7571.

22, 1966 Capitol Check-Up Day. Location: Lansing, MI. Contact: Donna LaGosh at MSMS at (517) 336-5788.

AMA Meetings

June

23-27, AMA House of Delegates Annual Meeting. Location: Chicago Hyatt, Chicago, IL. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty Society Meetings

April

13, Michigan Society of Anesthesiologists. Location: Ritz Carlton, Dearborn. Contact: Jennifer Anibal at (517) 336-7595.

18, Michigan Medical Group Managers Association Spring Conference. Location: Sheraton Hotel, Lansing. Contact: Andrew Lott at MSMS at (517) 336-7589.

18, Michigan Ophthalmological Society. Location: Radisson, Southfield. Contact: Andrew Lott at MSMS at (517) 336-7589.

26-28, Michigan Society of Medical Assistants Convention. Contact: Caroline Kimmel at (517) 336-7587.

May

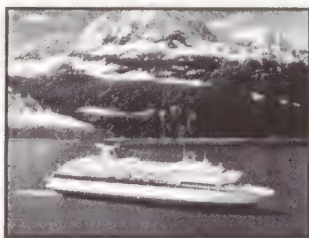
1, Michigan Dermatological Society. Location: Henry Ford Hospital. Contact: Jennifer Anibal at (517) 336-7595.

1-3, Michigan Society for Respiratory Care Annual Meeting. Location: Dearborn, MI. Contact: Caroline Kimmel at (517) 336-7587.

3-4, Michigan Society of Internal Medicine Spring Meeting. Location: Southfield, MI. Contact: Caroline Kimmel at (517) 336-7587.

15, Michigan Allergy & Asthma Society. Location: University of Michigan. Contact: Jennifer Anibal at (517) 336-7595.

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July 5 - 12; July 12 - 19, 1996

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T*his year's RSM is designed to help busy physicians
keep up with advances in clinical medicine.*

The MSMS Regional Scientific Meeting will offer choices of half-day sessions including immunizations, lipid disorders, hand and wrist disorders, a basic computer course, as well as others. **A morning "early bird" plenary session titled "Shoes," (the future of medicine), will be presented by Bruce H. Drukker, MD, Chairperson of Obstetrics/Gynecology and Reproductive Biology, Michigan State University College of Human Medicine.**

Mark your calendar today and watch for your complete MSMS Regional Scientific Meeting brochure in March.

Co-Chairs: **Tama D. Abel, MD, Ann Arbor**
Kamran S. Moghissi, MD, Detroit



Michigan State Medical Society
the Voice of 12,000 Michigan Physicians

For more information about the meeting and CME credits, please call the MSMS Office of Physician Education at (517) 336-5729, or by e-mail at scressman@msms.org

EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

March

18-22, PET and SPECT Imaging in Cancer Diagnosis and Treatment. **Location:** Ihilani Resort and Spa, Kapolei, Hawaii. **Sponsor:** Johns Hopkins Medical Institutions, Office of Continuing Medical Education. **Contact:** Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-2959. **Approved for:** 17 hours of Category I Credit.

19, Bar-Levav Education Association Ongoing Seminar Series "Ruminations: A Special Case of Functional Thought Disorders." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

22, Applied Clinical Informatics Symposium Topic on Information Systems of Immediate Importance for the Practicing Clinician. **Location:** Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School, Department of Family Practice, Michigan Academy of Family Physicians. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions,

University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

22-23, Infant Psychiatry: Models of Clinical Intervention for Infants & Families: A Multidisciplinary Approach. **Location:** Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

25-27, PET and SPECT Imaging in Cancer Diagnosis and Treatment. **Location:** Thomas B. Turner Building, Baltimore, Maryland. **Sponsor:** Johns Hopkins Medical Institutions, Office of Continuing Medical Education. **Contact:** Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Avenue, Baltimore, Maryland 21205, (410) 955-2959. **Approved for:** 18.5 hours of Category I Credit.

26, Bar-Levav Education Association Ongoing Seminar Series "The Psychotherapy of Hopelessness: A New Approach." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 6 hours Category I Credit.

27-29, 17th Annual Clinical Ses-

sions in Psychiatric Nursing: Maintaining Excellence in the Face of Change. **Location:** Topeka, Kansas. **Sponsor:** The Menninger Clinic, Division of Continuing Education. **Contact:** Continuing Education at Menninger, 1-800-288-7377.

28-29, Challenges and Changes in Obstetrics and Gynecology. **Location:** Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

30, Transvaginal Ultrasound Workshop. **Location:** Towsley Center, Ann Arbor, MI. **Sponsor:** The University of Michigan Medical School. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, 1-800-962-3555, (313) 763-1400.

April

2, Bar-Levav Education Association Ongoing Seminar Series "The Psychotherapy of Hopelessness: A New Approach." **Spon-**

(continued on following page)

Continued from previous page

sor: Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 6 hours Category I Credit.

9, Bar-Levav Education Association Ongoing Seminar Series "The Psychotherapy of Hopelessness: A New Approach." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 6 hours Category I Credit.

30, Bar-Levav Education Association Ongoing Seminar Series "The Values and Belief System of the Therapist: Examining Their Impact on the Psychotherapeutic Process." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

May

7, Bar-Levav Education Association Ongoing Seminar Series "The Values and Belief System of the Therapist: Examining Their Impact on the Psychotherapeutic Process." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-

Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

14, Bar-Levav Education Association Ongoing Seminar Series "The 'Alley-Cat' Syndrome: Finding the Suffering Patient Underneath." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

21, Bar-Levav Education Association Ongoing Seminar Series "The 'Alley-Cat' Syndrome: Finding the Suffering Patient Underneath." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

28, Bar-Levav Education Association Ongoing Seminar Series "Providing a Holding Environment for the New Patient." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

June

4, Bar-Levav Education Association Ongoing Seminar Series "Providing a Holding Environment for the New Patient." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

25-29, Internal Medicine 1996 - Advances and Controversies. **Location:** Dublin, Ireland. **Sponsor:** Mayo Clinic and the Department of Medicine, Royal College of Surgeons in Ireland Medical School. **Contact:** Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905 (800) 323-2688. ■

ONGOING

Case Studies in Environmental Medicine. **Location:** Your office/home (self-instructional monographs). **Sponsor:** The Agency for Toxic Substances and Disease Registry, Division of Health Education. **Contact:** Michele Borgiagli, Michigan Department of Public Health, Division of Health Risk Assessment, P.O. Box 30195, Lansing, MI 48909, (517) 335-9647. **Approved for:** Up to 33 hours of free Category I Credits; 1 per case study.

Rural Communities and HIV/AIDS

Conference

May 15, 1996

Grand Traverse Resort, Traverse City

HIV/AIDS has made its way into rural areas and small towns across the country. This growing presence poses a number of new challenges and concerns for health care providers. The Michigan State Medical Society will address many of the concerns confronting health care providers in rural areas of Michigan during a conference titled, "Rural Communities and HIV/AIDS."



Keynote speaker
Abraham Verghese, MD,
author of "My Own
Country: A Doctor's
Story," will share his
experiences of providing
HIV/AIDS care in rural
Tennessee.

This full-day conference will focus on issues including the challenges of providing HIV/AIDS care in rural settings, case management, and legal considerations related to HIV/AIDS. Concurrent sessions will discuss clinical care and medical care issues. And, a panel of persons living with HIV/AIDS will talk about their experiences and challenges they face.

The registration fee for this conference is \$100.

This conference may be offered as a video conference in a number of sites in Michigan.

For information, or to register, please call MSMS at (517) 336-5776.

Financial Supporters and Meeting Planning Committee:

Michigan Department of Public Health
Michigan State Medical Society
Thomas Judd Care Center
Michigan AIDS Fund
MSU Extension

Metro Health Foundation
MSU AIDS Education Project
Michigan Center For Rural Health
Michigan Health Council
Michigan Health & Hospital Association



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The following is a half-day continuing medical education program sponsored by Blue Cross Blue Shield of Michigan and presented by the Medical Staff of the Division of Infectious Diseases of Henry Ford Hospital.



Blue Cross
Blue Shield
of Michigan

"Infectious Diseases Update"

March 30, 1996



Location

Blue Cross Blue Shield of Michigan
Metro Service Center – Auditorium
27000 W. Eleven Mile Road
Southfield, MI

Registration

Office of Health Care Education
(313) 225-0163

Deadline for Registration

March 22, 1996

Purpose and Intended Audience

The purpose of this conference is to address current problems in infectious diseases. Selected conditions, with emphasis on the latest developments in their diagnosis and management will be covered. The presentations, targeted to primary care physicians, will be useful to all physicians.

Objectives of the Symposium

At the conclusion of the program, the participants should be able to:

- Describe presenting symptoms, clinical diagnosis, laboratory testing and management of selected infectious diseases.
- Discuss the diagnosis and treatment of resurgent and opportunistic infectious diseases.
- Identify and practice the standard of care of the conditions discussed.

Credit Hours

Blue Cross Blue Shield of Michigan, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of four (4) credit hours in Category I toward the requirements for Michigan relicensure and toward the Physician's Recognition Award of the AMA provided it is completed as designed.

AOA 1-A Credit sponsored by Pontiac Osteopathic Hospital.

Fees

Pre-registration required. Participating Blue Cross Blue Shield physicians—No fee. Non-Participating Blue Cross Blue Shield physicians—\$15.00 by check payable to Blue Cross Blue Shield of Michigan – CME.

CME Program Director

John J. Siller, M.D.
Associate Medical Director – Education
Blue Cross Blue Shield of Michigan

Program Director and Moderator

Louis D. Saravolatz, M.D.
Professor of Medicine C.W.R.U.
Division Head,
Infectious Diseases and Hospital Epidemiology

Program Agenda

- 7:15 AM Continental Breakfast
- 8:00 AM Welcome and Introduction
John J. Siller, M.D.
- Moderator
Louis D. Saravolatz, M.D.
- 8:10 AM Hepatitis C – Diagnosis and Treatment
Ramon del Busto, M.D.
- 8:55 AM HIV/AIDS Update for the Primary Care Physician
Noe B. Mateo, M.D.
- 9:35 AM Tuberculosis in Michigan and Beyond
Daniel A. Nafziger, M.D., M.S.
- 10:20 AM Break
- 10:40 AM Pneumonia – When do we admit?
When do we discharge?
Louis D. Saravolatz, M.D.
- 11:20 AM Approach to the Febrile Patient
in the Outpatient Setting
Noe B. Mateo, M.D.
- 12:00 PM Open Panel/Discussion
- 12:30 PM Adjourn

The views and opinions expressed by the speakers/panelists do not necessarily reflect those of BCBSM or current BCBSM medical policy.

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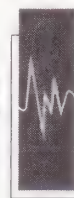


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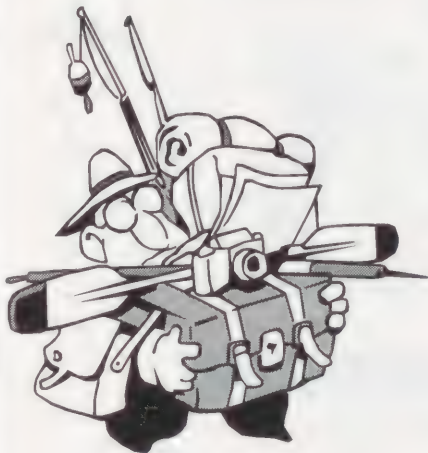
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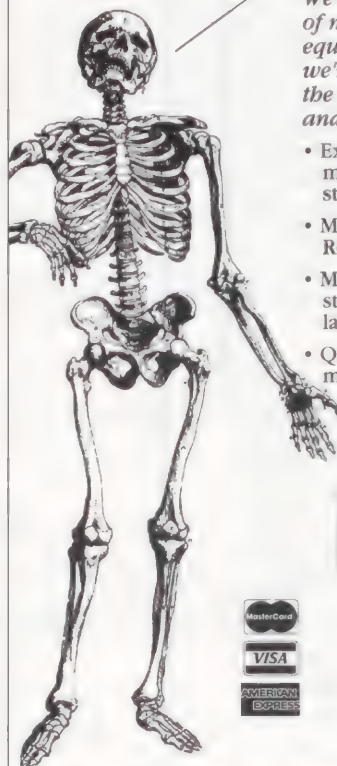
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Establishing a PSO

It could be our link to achieving success

By B. David Wilson, MD

Achieving success. How best can MSMS help physicians accomplish such a goal in today's increasingly competitive environment? It's a question MSMS, through its Task Force on Physician Networks, has been addressing fervently in recent months.

Our Task Force believes, as do I, that establishing a statewide physician network or HMO is not the answer. There are several reasons why, all of which are detailed in this month's cover story.

I agree with the Task Force that the alternative of establishing an MSMS Physician Services Organization (PSO), often referred to as a management services organization or MSO, may be just what we physicians need not only to survive, but to succeed in today's health care environment. I strongly concur with the Task Force that this alternative merits further study.

The purpose of an MSMS PSO would be to help not just individual physicians, but also physician groups, physician networks and physician hospital organizations (PHOs). Physicians need products and services to help manage their practices effectively. POs, PHOs and other similar entities also need products and services to help them

provide high quality, cost effective care in a managed care environment. An MSMS PSO would offer Michigan physicians a "physician friendly" alternative to hospital MSOs and for-profit physician management companies.

In my view, the key product that an MSMS PSO could provide is a **sophisticated management information system** that can help physicians manage care in a high quality, cost effective manner. Among the other services MSMS could provide through a PSO are:

- credentialing;
- practice guidelines and clinical protocols;
- capitation stop loss and other insurance products;
- assistance in the formation of group practices; and
- networking among POs.

MSMS already has some of these services available, including credentialing and capitation stop loss.

Over the next few months, MSMS will conduct market research to determine the level of physician interest in an MSMS PSO. In addition, along with the AMA and several other state medical societies, MSMS will conduct site visits to successful PSOs throughout the country to deter-

mine key PSO success factors. Finally, MSMS will discuss potential partnerships with other entities, including talking with state medical societies about the feasibility of a regional PSO.

All of this information, which will address the issue of whether or not to form a PSO, will be presented to the MSMS House of Delegates April 26-28 in Dearborn. I encourage all of you to make your views concerning this vitally important issue known to your delegates. As MSMS president, I also am very interested in hearing your thoughts concerning an MSMS PSO. Please feel free to E-mail me at bdwilson@msms.org. ■

Doctor Wilson is MSMS president.

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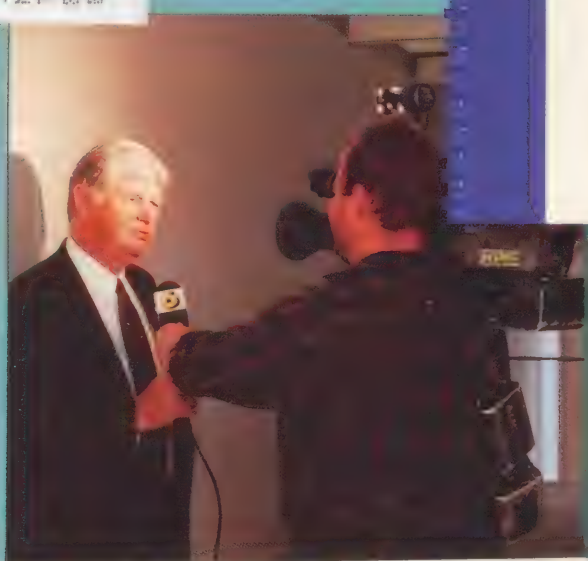
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COVER STORY



Michigan Health Plans

29

The Michigan State Medical Society recently conducted a groundbreaking study on Michigan health plans. Key findings from this evaluation are featured in this month's cover story. The study, which represents the first effort of the medical society to examine the operations and policies of Michigan health plans, is intended as a tool for MSMS members and others who have an active interest in health care delivery in Michigan.

Cover design by: Martin Hudson

FEATURES

INSURANCE INDUSTRY REPORT

MPMLC Enters New Markets

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This feature describes the savvy steps MPMLC has taken to diversify and grow — all of which spells good news for physicians.

By Thomas R. Berglund, MD

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MSMS participates in site visits to three California MSOs. This feature highlights the many "lessons learned" from these visits.

By Thomas M. Wolff

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Reap What You Sow

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A medical staff plan is critical to a community's success. So reports Jeffrey Towns, director of Medical Opportunities in Michigan.



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INFORMATION TECHNOLOGY

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From ledger cards to electronic networks 22

In response to an increasingly competitive business climate, medical practices, clinics and hospitals are now investing aggressively in third generation information technology.

By Robert P. Carlson

GIT CRITICAL ANALYSIS

Medicare 27

The MSMS Group Insurance Trust presents the fourth of a 12-part critical analysis of Medicare. This month's analysis addresses the interplay of Medicare and employer health insurance.

By Earl G. Moehn, MD

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MSMS Holds Fifth Annual Meeting 37

This feature presents four pages of photo highlights. Sections featured include international medical graduates, hospital medical staffs and young physicians.

MSMS MEMBERSHIP

Unity Means Power 42

Nothing rings more true for physicians. So says Louis R. Zako, MD, chair of the MSMS Committee on Membership Recruitment and Retention. This feature highlights the many efforts MSMS has taken — and plans to take — to unify Michigan physicians.

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Donald H. Huldin, MD 44

Lansing doctor recounts his experiences as a physician at Alcatraz.

By William Kendy

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Nominations may be made by an individual physician or by any interested party. Include a copy of the published article in which the research is presented plus the name, degree, title, address, organizational affiliation and phone number of the nominee. Deadline for nominations is May 10, 1996. Send materials to: Nora Malay, Program Officer; Excellence in Research Award for Physicians Program, BCBSM Foundation, 600 Lafayette E., B243, Detroit, Michigan 48226.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Question:

What is the greatest challenge facing young physicians today?

“The greatest challenge is juggling the multiple responsibilities of trying to balance good patient care while keeping up with changes in the insurance system. If the physician doesn’t master this, patients as well as income suffer.”

Jeffrey D. Mohr, MD, age 35
Family Physician, Grand Rapids

“I think the greatest challenge for the young physician fresh out of residency is how to integrate their practice and the art of medicine with the multitude of external factors. Physicians may not be trained in the increasing role of third-party payers, and non-healing issues.”

Donald G. Weston, MD, age 37
Anesthesiologist, Grand Rapids

“Assimilating the marketplace. Physicians have to practice medicine in a market with multiple payers, yet maintain professional integrity, remembering that their primary concern is the patient.”

Ronald L. Vanderlaan, MD, age 39
Cardiologist, Grand Rapids

“The greatest issue facing physicians, both young and old, is health care reform. Physicians are on the front line, like the “grunts” in Viet Nam. But, like Viet Nam, the policymakers and politicians are ignoring the grunts. If the people in Washington don’t listen to the physicians on the issues of health care reform, they’re going to lose the war.”

David H. Janda, MD, age 37
Orthopedic Surgeon, Ypsilanti

“For the future physician coming out of school, especially in anesthesiology, this issue is job security. This is becoming a major concern.”

Richard Y. Shin, MD, age 39
Anesthesiologist, Detroit

“Providing excellent health care with limited resources. Also, making treatment decisions with overriding cost and economic concerns.”

Michael D. Seidman, MD, age 35
Otolaryngologist, Detroit

“The biggest challenge is uncertainty over the direction health care is taking. This is evident in the choices both I and my colleagues have had to make. We all have this cloud hanging over our heads on how we should prepare for the future.”

Kenneth A. Parada, MD, age 37
Emergency Medicine, Cheboygan

“I would say managed care; staying economically viable under such systems, especially for the solo or small group practice. I think we’ll see more physicians in groups, becoming employed, or forming POs and PHOs in order to survive.”

David E. Randolph, MD, age 35
Internist, Midland

BackTalk is a nonscientific sampling of Michigan physicians’ opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax to (517) 337-2490, or e-mail bmcnerney@msms.org.



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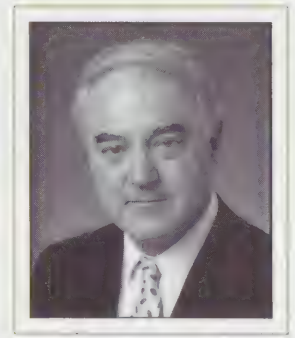


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Reporting patient driving impairments



By Richard D. Weber, MSMS Legal Counsel

Q: Are physicians required to report to the Secretary of State diseases, disorders or other infirmities which might affect a patient's ability to drive a motor vehicle?

A: Physicians are not required to report patient medical conditions which might affect a patient's ability to drive a motor vehicle. Although physicians are required to report patient conditions in multiple circumstances, the patient's ability to drive safely is not included. [For mandatory reporting requirements in other circumstances, legal counsel's article published in the April, 1994 edition of *Michigan Medicine* should be reviewed.]

Q: Is it permissible for physicians to report patient health conditions which might impair their ability to drive?

A: There is no clear answer to this question. The statute establishing the physician-patient privilege in Michigan states in pertinent part, "Except as otherwise provided by law, a person duly authorized to practice medicine or surgery shall not disclose any information that the person has acquired in attending a patient in a professional character, if the information was necessary to enable the person to prescribe for the patient as a physician, or to do any act for the patient as a surgeon." MCL § 600.2157. Although Michigan law provides many exceptions to the physi-

cian-patient privilege, there is no provision which permits a physician to report a patient's condition which may impair the patient's ability to drive. Under the plain language of the statute, the privilege forbids a physician from reporting this information.

The case law is more complicated. In *Saur v. Probes*, 190 Mich. App. 636 (1991), the plaintiff sued a psychiatrist alleging he revealed privileged information. The Court of Appeals held that the defendant could be sued for a violation of his legal duty not to disclose privileged communications. The Court also held that public policy requires that where it is reasonably necessary to protect the interests of the patient or others, a psychiatrist may breach the duty to maintain patient confidentiality, but that this was a question of fact for the jury. Although *Saur* involved the liability of a psychiatrist, the reasoning should be applicable to other physicians. Several other states have recognized an exception to a physician's duty not to disclose confidential information when the disclosure is in the public or the patient's interest.

A more recent Michigan Court of Appeals opinion offers another avenue by which a physician may voluntarily disclose confidential information. In *Alar v. Mercy Memorial Hospital*, 208 Mich. App. 518 (1995), the plaintiff sued a physician for disclosing to the

Air Force Academy that he had attempted suicide. As a result, the Air Force Academy revoked his admission. The plaintiff alleged that the physician was liable for breach of the physician-patient privilege. The Court of Appeals held otherwise. Applicants to the Air Force Academy were required to disclose any illness or injury. The Court reasoned that the integrity of the legal system demanded that it assume that persons with such obligations would honor them; and that the plaintiff would have informed the Academy of his suicide attempt if the physician had not. According to the Court, the breach of confidentiality was not, therefore, the proximate cause of the plaintiff's damages.

Michigan law prohibits the issuance of a driver's license to a person who is afflicted with a physical or mental disability or disease preventing that person from exercising reasonable and ordinary control over a motor vehicle. Pursuant to this law, a person who renews a driver's license is required to reveal whether he or she has an impediment that might prevent him or her from driving safely. Because the patient is required to reveal this information, under *Alar*, it may be permissible for the physician to reveal it as well.

Although the *Saur* and *Alar* opinions may arguably authorize a physician to disclose a patient's condition which

might affect the patient's ability to drive safely, there is no assurance that the physician would avoid liability. Courts have difficulty in balancing the strong public policy in favor of the physician-patient privilege against the strong public policy of protecting the safety of the patient and others.

Q: Do physicians have "good faith" immunity for reporting to the Secretary of State a patient's medical condition which might affect the patient's ability to drive safely?

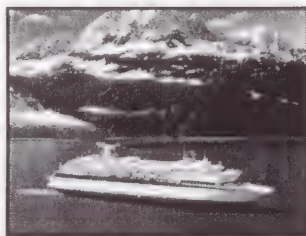
A: Although physicians have limited immunity in reporting medical conditions in other instances, no Michigan statute or appellate court decision has extended immunity to a physician who discloses medical information protected by the physician-patient privilege to the state relative to the patient's ability to drive. An argument could be made that the First Amendment protects the right of any person to inform government of information necessary for the enforcement of laws. Unless this general proposition is extended to the

specific instance of patient records, however, physicians should not rely upon immunity. ■

Mr. Weber is a senior member of Kerr, Russell & Weber, P.C.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to Betty McNerney, Editor of Publications, PO Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to bmcnerney@msms.org

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MPMLC Enters New Markets

Diversification benefits physicians, solidifies company's financial health

By Thomas R. Berglund, MD

Michigan Physicians Mutual Liability Company (MPMLC) took a leap forward by acquiring Kentucky Medical Insurance Company. The benefits to policyholders and competitive advantages it has created for us are truly exciting.

It's no longer true that Michigan Physicians can maintain financial health by "sticking to our knitting" -- that is, by providing only medical liability insurance to physicians in Michigan.

Integration in the health care environment demands that we grow in order to ensure the liability of larger entities.

Make no mistake -- this is a fast-paced, competitive insurance market in which new market entries are "buying" business by underpricing insurance. Those companies that stand still will not survive.

New products

Despite the competition and the changes in the industry, Michigan Physicians has maintained its market leadership position and continues to grow, diversify, and bring new products to you. Here are some examples: In 1993, we established Superior Employers Plan, a workers' compensation insurance program in Minnesota which generates \$11 million in premiums. In 1994, Michigan Physicians then developed a workers' compensation insurance program in Michigan, which writes more than \$1 million in premiums. In 1995, we created a medical liability insurer in Illinois, based in Chicago, called the RML Insurance Company. By the end of this year, we expect to write \$1 million or more in premiums. Then on Jan. 1, 1996, the purchase of Kentucky Medical Insurance Company (KMIC) was consummated. There is tremendous

opportunity for growth with this acquisition, since KMIC has licenses to operate in Kentucky, Indiana, Ohio, and Tennessee.

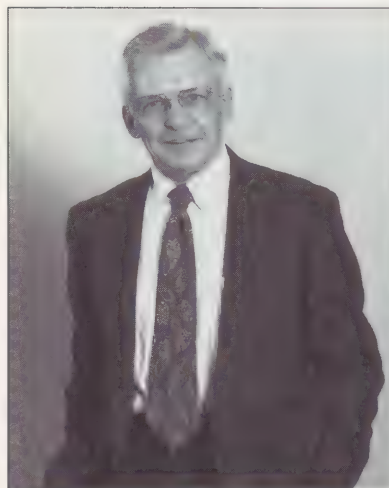
Think about it. In the past three years, Michigan Physicians has been transformed from a one-line, one-state company

into a regional property/casualty insurer. Michigan Physicians is extremely busy building, growing, and learning. Our ability to stay ahead and continue on a solid growth path, despite the extremely competitive environment, speaks well for our management and for the physician leadership of MPMLC.

Many benefits

Competitive rates. By spreading the risk to more insureds, across many states, we can price our insurance more competitively. With significant growth and by continuing to build our financial strength, Michigan Physicians is able to combat predatory pricing tactics of new market entries. We may not always be able to offer the lowest price in every circumstance, but then price should not be the overriding factor. As market leader, Michigan Physicians continues to be the best overall value for physicians.

Better insurance products. As healthcare providers build bigger entities, coverage needs change. As Michigan Physicians insures larger entities, we need more capital for reserves and surplus to cover larger liabilities. Also, in response to the industry's movement towards managed care and capitated systems, we've developed a new managed care liability package that covers not only medical liability but general liability and directors and officers liability. As healthcare entities take on attributes of big business, we have to be able to offer the insurance that large businesses require. In addition to managed care liability insurance, we've developed new stop loss insurance to protect hospitals and physicians against financial losses associated with capitation



(fixed payments per patient) contracts. Needless to say, our Research & Development Department has been and continues to be very busy.

Administrative cost reduction. Administrative costs can be reduced as the company grows. Efficiencies of operation are being immediately realized, for example, between Michigan Physicians and Kentucky Medical. Centralizing certain functions, such as information systems and underwriting is reducing the costs of offering insurance in other states.

Physician advocacy and staying power. Michigan Physicians has been a strong voice in the legislature with the Michigan State Medical Society during the past two rounds of tort reform (in 1986 and 1993). We helped pass the legislation that ultimately capped medical liability costs. Michigan Physicians supports many legislative efforts that favor physicians and continue to nurture our relationship with MSMS. In fact, our new stop loss insurance program has been jointly developed with MSMS. We continue to be MSMS's only endorsed medical liability insurer. For good reason.

Commercial insurers and other new insurers are not involved in the physician community. Unlike insurers that come and go depending on the profit outlook, Michigan Physicians has a deeper commitment to doing business in Michigan. Similarly, the Kentucky insurer we purchased is endorsed by the Kentucky Medical Association and is committed to the state's physicians.

A Michigan company. Michigan Physicians Mutual is a Michigan-based business, paying Michigan taxes and employing Michigan people. By purchasing insurance from MPMLC, you're supporting Michigan's economy. Our growth and financial success benefits our fine state.

In short, each of our policyholders benefits from our continued growth and diversification. We are aggressively maintaining our market leadership and our competitive advantages so we can serve you better. Our success is your success.

Doctor Berglund is president and chair of MPMLC.

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Case Study Underway

MSMS participates in site visits to three California MSOs

By Thomas M. Wolff

In a managed care environment, physicians need to be open to new ideas and willing to try new, more cost-effective ways of delivering care; physicians need to be innovative, creative and flexible.

This is just one of many "lessons learned" by MSMS which recently participated in site visits to three management services organizations (MSOs) in California: HealthCap, San Diego; CHS Management, Inc., Los Angeles; and Managed Care Systems, Inc., Sacramento. All three of these MSOs are in markets dominated by HMOs, with a considerable number of both primary care physicians and specialists being paid capitation. The site visits were part of an MSO case study being conducted by MSMS, the AMA, and several other state and specialty medical societies. A complete report of the case study will be available this summer from MSMS.

Other "lessons learned" from the site visits include the following:

- A sophisticated information system is vitally important to the success of an MSO. One physician stated that, "Information is the circulatory system of an MSO." A major MSO focus is to attempt to reduce variations in the cost and outcomes of treatment. An effective strategy is to compile data on individual physicians concerning how their practice patterns compare with those of their colleagues. The results are then shared with physicians in small groups. In most cases, this has apparently led to appropriate modifications in practice patterns.

- While the primary purpose of an MSO is to provide the infrastructure for physicians to provide cost-effective, high-quality care, a long-term benefit may be to eventually allow physician groups and networks to eliminate the middleman and contract directly with employers. This may be possible because MSOs provide many services typically performed by HMOs.

- Many California MSOs provide all the services an HMO provides except marketing and

actuarial services. These services include claims processing, credentialing, utilization management, quality improvement, provider relations, member relations, managed care

contracting and verification of member eligibility.

- Some MSOs are owned by physicians, while others are owned by hospitals, physician management companies (e.g., PhyCor, MedPartners) or any combination thereof.

- In California, HMOs prefer to contract through an MSO, rather than directly with individual physicians. MSOs receive a capitated payment from an HMO. Some MSOs capitate primary care physicians and pay specialists fee-for-service; others capitate specialists and pay primary care physicians fee-for-service; while still others capitate both primary care physicians and specialists. MSOs also base their payment to physicians in part on quality indices, including patient satisfaction surveys and outcome data.

- There appears to be a growing trend for an MSO to manage both group practice and physician network (IPA) models.

- The primary care case manager model and capitation of both primary care physicians and specialists are prevalent now in California. While these approaches may evolve, the key for physicians is to learn how to work within a defined budget. This is very challenging for physicians who are accustomed to fee-for-service reimbursement. One physician we met with stated that, "Physicians don't understand how to practice medicine under a budget." An MSO provides physicians with the tools for working within a budget.

- In California, health care premiums are falling, while patient expectations remain high. Thus, it is an extremely challenging environment in which to practice. One physician told us that, "Physicians' collective angst is very high now."

- A major goal of physician networks in

(continued on page 14)



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Continued from page 12

California at the present time is to consolidate in order to gain leverage vis-a-vis HMOs and hospitals. One of the MSOs we visited had just signed an agreement with MedPartners-Mullikin, under which they will now control about 900,000 covered lives. Their increased size will obviously give them greater bargaining power versus HMOs and hospitals.

- Key MSO success factors include:
- Experienced leaders with strong business and interpersonal skills.
- Capable staff.
- Vision: MSO leaders need to carefully examine their local market, ascertain the

direction in which the local delivery system is going, and build an MSO to meet the needs of employers, third party payers and physicians. In doing so, it is better to be proactive, rather than reactive.

- A sound business plan.
- A significant amount of capital (Physicians will likely need a capital partner.) ■

Tom Wolff is chief of PO Development for MSMS. If you would like more information about this case study, contact Tom at (517) 336-5740. His e-mail address is: twolff@msms.org.

MSO Expert Visits MSMS, Addresses MSMS Board

Stewart Gleischman, MD, chair, Health Source Medical Group, Los Angeles, Calif., recently visited MSMS headquarters to discuss strategies for developing a management services organization (MSO). He has been involved with a physician organization in California for the past 10 years and with an MSO for the past three years. Doctor Gleischman was the keynote speaker at the March 20 MSMS Board of Directors meeting held in East Lansing.

Michigan Medicine had the privilege of interviewing Doctor Gleischman during his visit to get his perspectives on MSOs. Following are some of his key comments.

On the role of MSMS in creating an MSO:

"I think the medical society is to be commended for the work it has done so far in making physicians aware of the fact that there are such things as MSOs -- what they do, what their utility is, why they may be necessary. I think that's definitely a role the medical society needs to play."

"MSMS is doing the right thing by becoming active early on. It's not a matter of MSMS forcing managed care on physicians; it is MSMS helping physicians develop the infrastructure they need to provide high quality, cost-effective care."

On the concept of a society-sponsored HMO:

"That idea would not be my first choice. It's a difficult task to do. I think it would be unlikely

for the society to be able to compete as effectively. It's a tall order."

On lessons learned in California:

"One of the key lessons is to be proactive rather than reactive. All Michigan physicians need to look at what's going on elsewhere in the country, take a look at their own practice environment and come up with a plan of some sort for the future. For some physicians, the plan may be to just continue doing what they're doing and retire. For others, it may involve identifying strategic partners. Those types of partners may be the medical society, other physicians, hospitals, HMOs or any number of other opportunities out there."


On the role of an MSO:

"MSOs don't have to deal with managed care only. They can help physicians recognize and realize extra value from their practices even if the majority of their work is PPO or indemnity. The advantage is for physicians to organize themselves into effective negotiating and bargaining and business units early in the process rather than suddenly finding themselves in a business situation for which they're ill-prepared."

On physician skepticism toward MSOs:

"The infrastructure you develop is useful to you whether you do indemnity or PPO work. At some point it will be important for physicians to have administrative talent, a real understanding of the business of health care delivery so that they can go out and negotiate and contract with some strength." ■





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Reap What You Sow

Medical staff plan is critical to a community's success

By Jeffrey Towns

Direct involvement by established physicians in designing and implementing a medical staff plan is critical to a community's success in harvesting the scarce crop of primary care physicians and some specialty physicians so needed in our state.

The national shortage and maldistribution of primary care physicians, in both rural and urban areas, has created tremendous competition within the employment market for these professionals. Over 5,000 hospitals and health systems, 600 commercial search firms, and hundreds of HMOs and other full-time employers are all dipping into the same limited recruitment well of medical professionals.

For most rural communities, the average length of time it takes to recruit a primary care physician is over two years. Consequently, this leaves many communities with restricted access to basic health care resources. As a result, the population is forced to seek health care services outside the community which causes decreased health care expenditures within the community and increased financial strain on the local hospital and existing physician practices.

Each day in Michigan there are an average of 390 primary care positions on the Medical Opportunities in Michigan (MOM) system, a system representing the majority of existing employment opportunities statewide for physicians. Of key concern is the retention of those who are educated here, or who currently practice in our state. Focusing on family physicians for example, of all residents exiting Michigan programs, it is estimated that we will retain only about 30 who will be involved in direct patient care to fill the over 175 positions available on MOM. About half of residents will leave the state, while those remaining will enter academics, fellowships and research, leaving a scant few to fill the ever increasing demands of an already underserved population. Compoun-

ding the problem is that a large portion of family physicians are nearing retirement age, with approximately 25 percent currently over age 55. All this is occurring at a time when there already exist over 15,000 vacancies nationally for family

practice physicians alone.

In contrast to primary care is the physician specialist market. There is a shrinking pool of opportunity for many specialists as the constraints and market forces of managed care take hold. The MOM system averages approximately twice as many opportunities for primary care physicians as all subspecialist opportunities combined. However, the system has proven to be a valuable resource for many specialists in locating employment opportunities through its centralized approach to opportunity information. But getting a physician into a community is only the first step. Once recruited, it is the established physicians who wield the greatest influence in retaining a new physician in the community.

Playing an active role in the development of your community's medical staff plan not only helps ensure that the community's current and future health care needs are met, but provides for the overall financial stability of the local hospital and physician practices, with each ultimately relying on the other.

When contemplating your involvement in a medical staff plan, consider that the most influential professional factor for a physician in selecting a practice location is the other physicians in the community.

So what can you do?

- Plan ahead for your own practice needs and be aware of your community's future physician trends.
- Participate and support the community medical staffing plan through your local hospital or health care organization.

"The involvement of the state's established population is critical to providing a fertile, welcome environment for the physicians so desperately needed... in our state."

- Actively participate in the recruitment and retention of physicians in your community through involvement in site visits, follow-up communication, and social interaction with new recruits.

- Provide mentoring for physicians new to the area, as well as interaction with their peers.

- Be involved in the development of a call-coverage plan. Call coverage is a key factor in a physician's practice selection.

- Be familiar with the MOM system and the information services available through the Michigan Health Council as a useful resource for your community and practice.

Like the rest of the nation, the employment environment for physicians in Michigan is changing as fast as the employers and managed care organizations that influence it. The involvement of the state's established physician population is crucial to providing a fertile, welcome environment for the physicians so

desperately needed for health care provision in our state. ■

The author is director of Medical Opportunities in Michigan, a service of the Michigan Health Council (MHC). MHC is a non-profit organization which serves the health care needs of Michigan. For more information on the Council, its services or physician supply in Michigan, call 1-800-479-1MOM.

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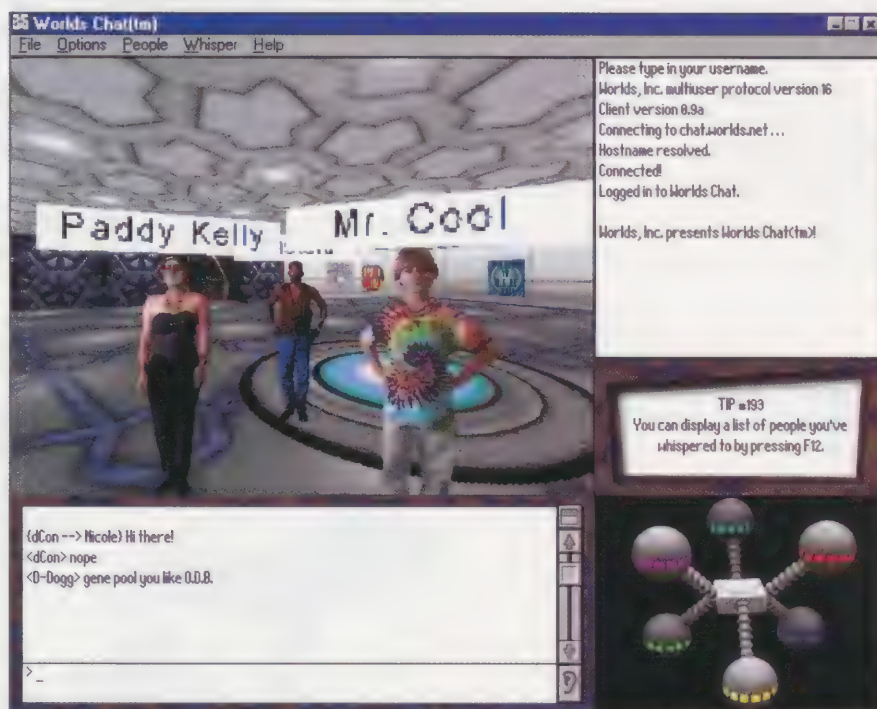
Real-Life on the Web

One of the promises of the Internet is the ability to communicate in a natural, comfortable manner with any other Internet user. Designers at Worlds, Inc., have developed the most advanced Internet communication interface to date at Worlds Chat. Their software, based on an emerging VRML (virtual reality modeling language) standard, places you in a computer-rendered three-dimensional world which you view from a first-person perspective. Put simply, you look out on a landscape of objects, terrain, and other users. The software connects to a central computer over the Internet, and allows you to interact with hundreds of other users in real-time. You will be represented by your own on-line "avatar," allowing you to see and interact with the "avatars" of other users. There is even a "mirror" available that allows you to see how your "avatar" looks to others.

The program comes with several pre-defined "avatars," one of which you must choose before going on-line. In addition, an "avatar" editor can be downloaded from Worlds, Inc., that gives you the tools needed to create your own on-line alter ego. The program requires a 486/50 or better PC with 8MB of free RAM, 7MB of free disk space on your hard

drive, Windows 3.1 or Windows 95, a 16-bit sound card such as SoundBlaster16, and a display that supports 256 color mode. The software and more information can

be found at <http://www.worlds.net/>. Now, the next time you hear "see you on-line," you can make it happen.



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Configuring Netscape to access MSMSNET

Many physicians rely on MSMSNET as their source for up-to-date information regarding

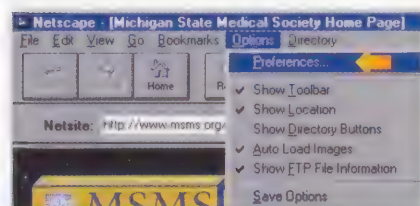


Figure 1

Internet medical resources and links to interesting sites. With a few simple steps, you can streamline your access to MSMSNET and keep our information at your fingertips. By designating MSMSNET

as your homepage, Netscape will automatically load MSMSNET each time you connect to the Internet, and you will be able to reload MSMSNET from anywhere on the Internet by pressing the "Home" button. Follow these steps to reconfigure your software:

1. From the Options menu, choose Preferences... (Figure 1)
2. Click on the Styles Tab. (Figure 2)
3. Choose Home Page on the Start

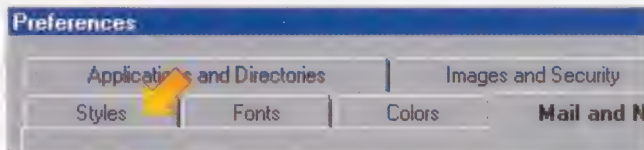


Figure 2

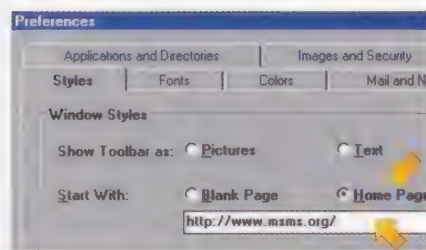


Figure 3

With: line and enter <http://www.msms.org/> in the location box. (Figure 3)

4. Click on "OK" to exit the configuration process.

Have any suggestions for MSMSNET?

MSMSNET is striving to become a more interactive World Wide Web (WWW) site. If you frequent MSMSNET, you may have noticed some new features...Site of the Week, and Fun Stuff. These new pages, along with Internet Sites, are a quick way to find useful and interesting information on the WWW. This is where a more interactive MSMSNET can be truly beneficial. Attempting to catalog medical resources on the Internet is an enormous task, and filtering out the less useful resources makes it even more difficult. If there are any web pages that you have found to be valuable, or fun and interesting, we would like to know. E-mail your suggestions to Andy Clay at aclay@msms.org. Enhancing our interactivity will help make MSMSNET a truly valuable resource for Michigan physicians.

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Services, contact Andrew T. Clay at MSMS via E-mail at aclay@msms.org or by phone at (517) 336-7601.

Physician's Guide to Michigan Law available on-line

Physician's Guide to Michigan Law, a printed document published cooperatively by MSMS and MPMLC, is now available on MSMSNET. The guide, prepared with assistance from MSMS legal counsel, helps physicians learn and understand the many Michigan statutes and regulations which affect the practice of medicine.

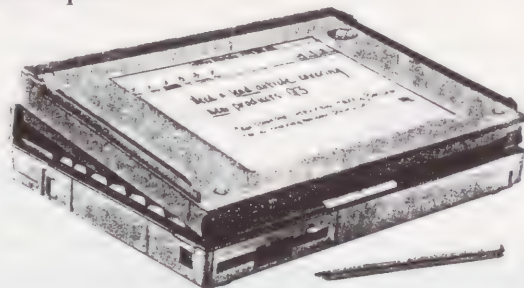
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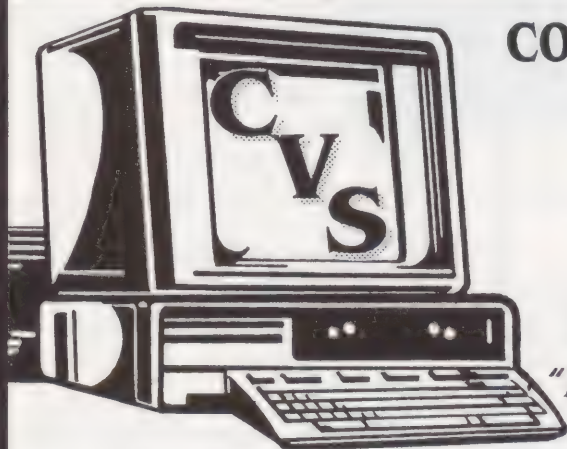
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Information Systems:

From ledger cards to electronic networks

By Robert P. Carlson

As an industry, health care has lagged behind other sectors of the economy in exploiting the tools of information technology. But that may not be true much longer. In response to an increasingly competitive business climate, medical practices, clinics, and hospitals are now investing aggressively in third generation technology to integrate their internal information processing functions and to share information with their trading partners via electronic networks.

Looking back, it's easy to see that each generation of information systems reflects the business climate in which medicine is practiced, and that each new generation is a response to major changes in business conditions.

First generation systems

First generation medical information systems of the 1950s and 1960s included tools such as #2 pencils, electric typewriters, ledger cards, pegboards, and punchcards. If you wanted to transmit information, your options were the telephone and the US Postal Service. Those were the golden years of medicine, and if you were practicing back then, it may have seemed as if they would never end.

Second generation systems

With the emergence of Medicare, Medicaid, and commercial insurance carriers, physicians were faced with more rules and regulations, more detailed claim

forms, and more paperwork, even for privately insured patients. The "hassle factor" increased the cost of doing business, but at the same time, limits were placed on reimbursement. To cope with this increasing complexity, many practices used new practice management systems that utilized a new device called a mini computer to schedule patients and to generate statements, produce claims, and create management reports.

These second generation information systems really came into their own when IBM introduced the first PCs, or personal computers, in the early 1980s. Suddenly, you could do many of the things the mini computers were doing, and sometimes more. Leading edge medical practices soon began submitting their claims electronically by

connecting their PC directly with their insurance carriers' computers.

Third generation systems

With the rise of global competition in the 1980s, no sector of the US economy was immune from market pressures to cut costs and improve quality. Rising health care costs became an obvious target. Health care reform legislation failed, mostly for political reasons and be-

cause managed care organizations were taking the initiative to deliver low cost medical care,

(continued on page 24)

"In the current business climate...it's easy to see how the benefits of doing business via electronic health care networks translates directly into enhanced cash flow and a decisive competitive advantage."

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Continued from page 22

and make a profit besides. Today's third generation health care information systems are responding to these cost-cutting pressures and to the rise of managed care.

According to Tom Thomas, national sales manager for Computers Diversified, Inc., **the two dominant trends in health care information technology for the foreseeable future are:**

Electronic Communications. In addition to traditional practice management functions, providers must now communicate with their trading partners in an efficient and timely manner to process and share information.

Data Collection and Reporting. With the emergence of managed care, providers must now be able to collect, massage, report, and interpret their transaction data.

Electronic networks

Medical practices, hospitals, insurance carriers, laboratories, financial institutions, collection agencies, and other trading partners who are connected with each other in electronic health care networks can now move data on-line, in real time. Submitting an electronic claim, retrieving lab results, or inquiring into a hospital's information system now takes seconds instead of hours or days. For the data collection and reporting functions of your practice, electronic health care networks provide access to up-to-the-minute information.

In the current business climate, when every cost is under scrutiny, when competitive pressures affect every health care entity, when government and insurance carrier regulations and standards are a fact of life, and when there is significant downward pressure on reimbursement, it's easy to see how the benefits of doing business via electronic health care networks translates directly into enhanced cash flow and a decisive competitive advantage.

A local source

One of the largest operational electronic health care networks in the country is

headquartered right here in Michigan. Southfield-based Computers Diversified, Inc. (CDI), a division of Medifus Corp., has carried the endorsement of the Michigan State Medical Society for its practice management product since 1987.

Today, the CDI Electronic Health Care Network moves millions of transactions daily for thousands of providers and trading partners throughout the country. In Michigan alone, CDI connects more than 4,000 MSMS physicians to:

- major commercial and hospital laboratories;
- hospital information systems;
- credit card processing services;
- payer community;
- cash management systems;
- electronic mail systems; and
- collection agencies.

For more and more providers, electronic health care networks are essential for success in the current health care marketplace. ■

The author is an Indianapolis-based health care writer.

Comment Line

If you would like to comment on an article in *Michigan Medicine*, or any other aspect of the magazine, please do not hesitate to contact Betty McNerney, Editor of Publications, at (517) 336-5749, or by FAX at (517) 337-2490, or E-mail at bmcnerney@msms.org

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*- Howard Comstock, MD
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Medicare:



Number 4

Complex Decisions: The Interplay of Medicare and Employer Health Insurance

by Earl G. Moehn, MD, Chair, MSMS Group Insurance Trust



As you (and your spouse) approach age 65, you face complicated decisions about health care coverage. It rarely is as easy as simply signing up for Medicare Part A and Medicare Part B. Your choices depend on the size of your company, whether you continue to work after turning 65, and the age, work status, and health insurance coverage of your spouse.

To make matters even more confusing, when you *can* sign up for Medicare Parts A and B and when you *should* sign up for them may not be the same. Moreover, all of these decisions are influenced by the rules of primary and secondary payment.

The following discussion assumes that you are involved with a practice that provides you with an employer-sponsored health plan and that you are carrying the health insurance for both you and your spouse.

Primary and Secondary Payers

Some definitions are in order before we delve into the intricacies of Medicare and other private health insurance. If you have Medicare and other coverage, the *primary* payer is the plan that pays first on your health insurance claims. The *secondary* payer pays second on your claims. Both primary and secondary payers pay only for services that are covered in their respective policies. In other words, a service not covered by the primary payer is not necessarily covered under the secondary payer's policy. When Medicare is the primary payer, Medigap insurance (Medicare supplemental insurance, detailed in last month's Critical Analysis) fills some of the gaps in Medicare coverage.

The Rules: Businesses with Fewer than 20 Employees

When a person involved with a small firm turns 65, Medicare becomes the primary payer (for an exception to this rule, see the next section), and you will be wise to enroll in Medicare Part A as soon as you are eligible to do so. (The initial enrollment period for Medicare is the seven-month period that begins three months before your 65th birthday, includes the month you turn 65, and ends three months after your birthday. Your Medicare coverage will start with the month you turn 65, if you enroll during the first three months of your enrollment period. If you enroll in the last four months, your coverage will begin one to three months after you enroll.) For most people, Part A requires no premium.

Deciding whether to enroll immediately in Medicare Part B is more difficult. If the employer health plan covers most, all, or even more than Part B covers — at an affordable price — you may wish to delay enrollment in Part B; if you delay enrollment in Part B, the employer plan is the primary payer for *both* Part A and Part B. In this case, Medicare is the secondary payer for Part A but not for Part B, because you have not yet enrolled in Part B.

Delaying enrollment in Part B may be worthwhile, because it preserves the six-month open enrollment period, during which you can sign up for (1) Part B, without financial penalty, and (2) a Medigap policy, without submitting to medical underwriting that may drive up your premium. In addition, if you delay enrollment, you can enroll during the seven-month period starting in the month in which (1) you and your spouse quits working or (2) you stop being covered by your

(continued on following page)

Critical Analysis



Michigan State Medical Society
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employer health plan, whichever comes first.

Even if your employer coverage is comprehensive, however, you may have to pay a large share of the monthly premium. In such a case, the \$42.50 monthly premium for Part B may provide you with sufficient coverage for less cost; if this is the case, you may decide to decline your employer plan and enroll in Part B when you are initially eligible. In this case, Medicare becomes the primary payer for both Parts A and B.

Unlike larger firms, businesses with fewer than 20 employees are allowed to offer Medigap policies to employees who continue to work after turning age 65.

The Rules: Businesses with 20+ Employees

If you are part of a business having 20 or more employees, the rules are quite different. If your place of business offers private health insurance, and you continue working after turning age 65, the employer-sponsored plan is the primary payer and Medicare is secondary. Moreover, when you turn 65 and opt to continue working with the firm, the employer is not permitted to alter the benefits covered — the employer must offer the same benefits to both older and younger workers. In this case, you should enroll in Medicare Part A, even if you choose your employer coverage: There is not a premium and Part A can supplement your employer policy.

Again, Part B may be a different matter. If your employer plan offers comprehensive coverage with premium sharing that you can afford, you may choose to postpone signing up for Part B. You could decide, however, to enroll in Part B, paying the monthly premium for services not covered by your employer's plan. Your decision depends on how much your employer plan covers, how much of the premium you must pay, and whether you can afford the Part B premium.

When employees of small or large firms turn 65, they always can choose to decline employer-sponsored coverage. High premium sharing or inadequate coverage may make it wiser to enroll in Medicare Parts A and B and forego the employer plan. But don't take that route before considering the effect on your spouse if s/he is not yet eligible for Medicare. Despite the premium, you may have no choice but to stay with the employer plan, because without it your spouse will be without health insurance.

With larger firms, if you opt for Medicare because the employer plan covers little or your share of the premium is high, the employer *cannot* offer you a Medigap policy or help you pay for such coverage. You must purchase it on your own. An employer may, however, offer a plan that pays for health services not covered by Medicare, e.g., hearing aids, routine dental care, physical checkups.

Retirees

Some workers who retire at or after age 65 have private health insurance through their former employer. Retiree plans may or may not conform to those offered to employees who continue to work past age 65; often the retiree plan is less comprehensive and requires higher cost sharing. Employers of any size can convert their plan to a Medigap policy for their retirees.

Retirees, then, face especially tough choices when they strive for a good fit among employer-sponsored retiree health coverage, Medicare, and Medigap. They have to decide which coverages to maintain, decline, or postpone. For example, if an employer plan for a retiree covers prescription drugs, which Medicare does not, your need for that benefit will dictate whether you maintain the employer plan or choose instead to decline it and purchase a Medigap policy that includes prescription coverage among its benefits.

Retirees must keep in mind that no law protects them from an insurer who might try to sell them a Medigap policy that *duplicates existing employer-sponsored* coverage. The 1990 law that standardized Medigap policies means only that insurers cannot sell Medigap policies that duplicate *Medicare* benefits.

Conclusion

In the final analysis, everyone approaching age 65 must decide on health insurance coverage based on their unique circumstances. *Every case is different.* Perhaps more than at any other time in your life, you must understand the complexities of health care and health insurance. ■

This is the fourth in a series of monthly articles that examine aspects of Medicare.

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Evaluation of Michigan Health Plans



Executive Report
1996

Digging Beneath the Surface of Michigan Health Plans

MSMS study aims to provide physicians, patients with the information they need

The 1996 Michigan State Medical Society Evaluation of Health Plans represents the first effort of the medical society to conduct a detailed examination of the operations and policies of Michigan's health plans. It is intended as a tool for MSMS members and for others with an active interest in health care delivery in Michigan.

This evaluation is not a report card, nor is it an attempt to duplicate comprehensive regulatory oversight or National Council on Quality Assurance functions. It is an effort to examine health plan policies and programs from the perspective of physicians and patients. It provides a set of baseline information that MSMS can use to track changes in our system and changes relating to individual plans.

Information for this evaluation was collected from several sources. A detailed questionnaire was sent to all Michigan managed care plans and major indemnity insurers. We appreciate the cooperation of Aetna Health Plans, Blue Cross Blue Shield of Michigan, MCare and Priority Health who completed our questionnaire.

For these and all other plans included in our evaluation, available information was gathered from reports filed with the State of Michigan, including the Michigan Insurance Bureau and the Michigan Department of Public Health. Several plans have offered to discuss the evaluation with MSMS, and additional information gathered through those discussions will be included in future revisions to the evaluation.

Our efforts to develop a comprehensive evaluation of health plans in Michigan highlight disparities in regulation of health benefits in Michigan. Information on the financial health, organizational structure, utilization management programs, quality assurance activities, benefits and contracting practices of licensed health maintenance organizations is available, because of the comprehensive regulatory requirements affecting

these plans.

MSMS could not collect similar information about other organizations which are administering health benefit plans or offering coverage through preferred provider or other, more loosely regulated, arrangements. Third party administrators, network managers, and

managers of "niche" products for specific services, such as mental health or diagnostic laboratory services, play an increasingly important role in how health care services are delivered and financed. These and other entities providing administrative and other services to self funded benefit plans are not subject to the same high standards of public accountability as the plans described in this report. This lack of public accountability deserves further attention, as policymakers and the public continue efforts to obtain better information about health care services.

A summary report provides an overview of several issues examined through our evaluation.

Information about individual plans is available from MSMS. This information includes all or part of the following: financial analysis, corporate structure, quality assurance programs, physician participation and credentialing information, benefits, payment mechanisms, appeals and grievance procedures and administrative issues. As we continue our discussions with individual health plans, this information will be updated, in an effort to provide the most current information available.

Financial Analysis

Some observations about our financial analysis include:

- Michigan health plans appear to be in good financial health.
- Medical loss ratios for Michigan HMOs and Blue Cross Blue Shield of Michigan were

fairly consistent for 1992 to 1994.

- Most Michigan health plans maintain medical loss ratios at or above the national average.
- Administrative costs vary widely among plans. Some plans are experiencing changes in administrative cost, that may be associated with the costs of National Council on Quality Assurance accreditation preparation.
- Changes in administrative costs also may reflect shifts in contracting practices, where administrative spending occurs at the IPA or other contractor level.

Physician Participation

Physician participation with Michigan HMOs has grown steadily. Chart 1 shows growth in participation from 1993 to 1994; this information reported to the state is confirmed by MD Data, the MSMS Survey on Physician Practice Characteristics.

Each plan files information regarding termination of physician contracts, but reasons for termination are not reported consistently. PPOs are not included in these reports, and we know anecdotally that these programs have experienced tremendous shifts in recent years. As we continue to develop information for our ongoing evaluation, we hope to provide more detail in this area.

Many HMOs included in this executive summary offer point of service options, and use the same physician network for both HMO and point of service plans.

Some highlights of our review of issues affecting physician participation include:

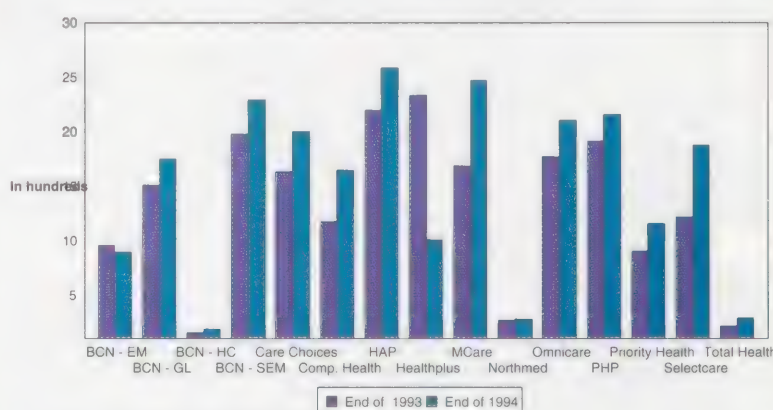
- Many HMOs are open to new physicians as enrollment continues to grow. In many cases, they are open selectively (i.e., in certain geographic areas or specialties).
- The proportion of board certified physicians is growing.
- Contract issues are important to physicians considering participation. Gag rules are not prevalent in Michigan; contractual provisions that hold a managed care plan harmless for liability, and that allow the contract to be terminated without cause, are currently a bigger concern in Michigan.

Utilization Management and Quality Assurance

The evaluation included review of physician visits and hospital days per 1,000 members, and

future evaluations will examine utilization data more thoroughly. Currently, use in Michigan is generally higher than in states with high managed care penetration, but this is due to a number of factors. Health status, changes in patient mix, utilization management initiatives, technology and medical advancements, and shifts in services from inpatient to outpatient settings all

Physician Participation in Selected Michigan HMOs



Source: 1994 Annual Reports, Michigan Insurance Bureau

impact the utilization reported by Michigan health plans.

All plans reporting to the Michigan Department of Public Health and responding to the MSMS survey use a variety of tools in utilization management efforts. These commonly include feedback to physicians through profiling, whereby physicians receive information on their use of services compared to overall patterns. Prior authorization for hospital admissions and prior authorization for some outpatient services is often required.

Many plans have developed initiatives to address utilization of specific services. In some cases, these may be "carve-outs" related to broad categories of services, such as mental health, diagnostic radiology and diagnostic laboratory. In other cases, measures may focus on specific procedures, such as outpatient or inpatient surgical procedures. Many national vendors have

Continued on following page

Continued from previous page

developed guidelines for use in utilization management initiatives; further discussion with each of the plans is needed to fully understand how these guidelines are developed and used.

Each of the plans reporting to the Michigan Department of Public Health include quality management plans. For 1994, an increasing emphasis was being placed on preventative measures

- Chart 2 provides a summary of the type of complaints received by selected Michigan HMOs in 1994. A large number of complaints relate to administration of specific claims; a still larger number involve access to health services, suggesting an ongoing need to help patients understand their changing coverage.

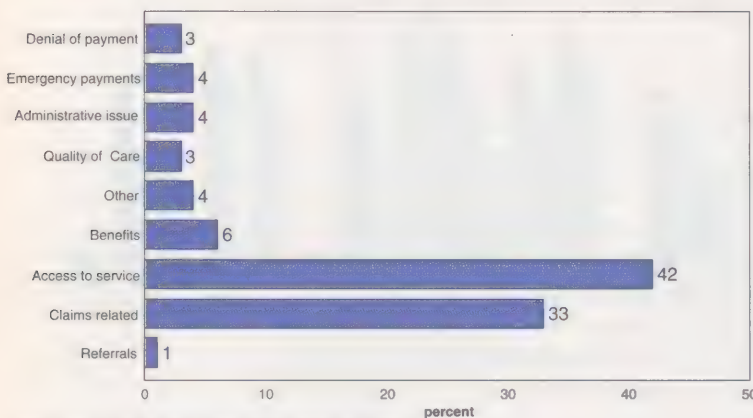
Future Steps

This first evaluation of Michigan health plans highlights many areas for further review and action. MSMS will pursue several measures to continue to provide information and advocacy for physicians and patients, including:

- Review 1995 plan information, which should be available this spring. New information from our review of state regulatory filings, updated information from plans responding to our survey, and new information from plans that have offered to participate in our efforts, will be incorporated in future MSMS evaluation activities.
- Expand our information tools through development of a financial analysis of Michigan hospitals.
- Work with health plans toward consistency with MSMS principles relating to utilization management, medical review and physician data.
- Pursue passage of legislative measures, including a Patient Bill of Rights that regulates all types of health plans and legislation that improves administrative efficiency through standardized claims reporting.

For more information on the MSMS Evaluation of Michigan Health Plans, contact Mary Anne Ford, Manager, MSMS Department of Medical Economics and Health Care Delivery. Phone: (517)336-5721. E-mail: maford@msms.org.

Categories of Complaints for Selected Michigan Health Plans



Source 1994 Annual Reports, MDPH, MSMS health plan survey

and management of chronic conditions.

Member Service

Annual reports filed with the Michigan Department of Public Health include information on the number and type of member complaints and grievances received by each plan. Complaints include member contacts with the plan on specific issues of concern; grievances are more formal and each of the plans who report this information to the department have processes for grievance resolution. Highlights of our review of member grievance and complaints revealed areas for further action:

- Benefits and issues involving care received outside of the plan or network are among the most common causes of formal grievances.

MSMS Releases Study; Several groups gather for official unveiling

MSMS officially unveiled the findings of its 1996 Evaluation of Michigan Health Plans at MSMS headquarters March 21. Several groups gathered throughout the day to learn what the first-ever study conducted by MSMS found. Groups included physicians, leaders of physician organizations, health-related associations, patient groups, business coalitions, purchasers, unions, and state legislators. Following are photo highlights of the event.



MSMS Board Chair Peter A. Duhamel, MD, explained the findings of the health plan evaluation to a reporter from WLNS TV-6, a CBS-affiliate located in Lansing.



MSMS released key findings of its Health Plans Evaluation to state and local media at a press conference at MSMS headquarters March 21. Speaking before the media was Mary Anne Ford, manager, MSMS Department of Medical Economics and Health Care Delivery.



Gerald Faverman, president of The Faverman Group, a Lansing think tank, was one of nearly 200 people who gathered at MSMS headquarters for the unveiling of the Health Plans Evaluation.



John T. Kerr, vice president, Hospice of Michigan, gathered with representatives of other patient groups for the official unveiling of the evaluation.



"We hope this report will be used to begin a dialogue among physicians, insurers, consumers and employers to improve health care delivery in Michigan," MSMS Board Chair Peter A. Duhamel, MD, told representatives of patient groups who attended a briefing at MSMS headquarters.



"This study provides more information than we had before," said David Cuneo, president of Health Care 2000, Grand Rapids. "It will help us in the process of evaluating the different plans and how they perform. We will share this information with members of our coalitions which, in turn, will allow them to ask questions of their plans and to hold them accountable."

It was standing-room-only at MSMS headquarters as physicians gathered to hear the results of the 1996 MSMS Evaluation of Michigan Health Plans.



More Michigan health plans spend more of each premium dollar on direct patient care than the national average, MSMS President B. David Wilson, MD, told legislators who gathered for a briefing at MSMS headquarters.



What questions should patients ask when choosing a health care plan? MSMS Board Chair Peter A. Duhamel, MD, holds up a new patient information brochure developed by MSMS which provides those questions.



Contact MSMS for information or assistance

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Direct Phone—(517)336-5722

POs/PHOs

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Physician Hospital Relations and Outreach

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Michigan State Medical Society has published its evaluation of Michigan health plans. Members may order one copy of the Executive Report or the Comprehensive Report Document, covering all plans, at no charge. Additional reports may be purchased at the prices listed below (includes postage and handling). Individual Reports on particular plans are \$10.00 each (includes postage and handling).

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MSMS Hold Fifth Annual Session

Approximately 150 delegates, alternate delegates and guests attended the Fifth Annual MSMS Joint Section Meeting held March 1-2, 1996 at the Ritz Carlton Hotel, Dearborn. The combined MSMS Sections for International Medical Graduates, Hospital Medical Staffs and Young Physicians considered a total of 33 resolutions. Following are photo highlights of the meeting.



MSMS President B. David Wilson, MD, welcomed Section delegates and guests to the meeting. Of the 33 resolutions debated at the meeting, several were referred to the MSMS House of Delegates.



Doctor Benjamin (center) was on hand throughout the entire Joint Section Meeting to offer her input and advise on issues facing organized medicine. Pictured with Doctor Benjamin are MSMS Managing Director Kevin A. Kelly (left) and MSMS Board Chair Peter A. Duhamel, MD.

Regina M. Benjamin, MD, Alabama family physician and first designated young physician member of the AMA Board of Trustees, was one of four keynote speakers at the meeting.



Frank M. Houser, MD, newly-named president of physician management services, Columbia HCA Health Care Corporation, Nashville, Tenn., discussed Columbia's partnership with physicians in his keynote address.



John G. Wiegstein, MD, co-president and HMSS representative, Michigan Capital Medical Center, Lansing, provided his perspective on Columbia HCA's strategy in Michigan during his luncheon presentation.



International Medical Graduates

Of the eight resolutions before MSMS IMG Section delegates, none was more hotly debated than the one which called on MSMS to urge the AMA to form an IMG Network. An AMA IMG Network would provide IMGs with a vote in the AMA House of Delegates.



Busharat Ahmad, MD, (right) expressed his strong desire for the establishment of an AMA IMG Network. Listening intently were: Edgar P. Balcueva, MD (left), immediate past chair of the IMG Section; and AMA staff member Jack Hoteling (middle).



IMG delegates gathered for a caucus Friday evening where they spent more than one hour discussing the concept of an AMA IMG Network. On hand to field questions was AMA Board Trustee Regina M. Benjamin, MD.



MSMS IMG Section Chair Kenneth A. Jordan, MD, discussed his goals for the Section, which include finalizing work begun on the establishment of an acceptable course in English Language Development for IMGs.



Reference Committee staff heard heated testimony on Resolution 1-96IMG, which called for the establishment of an AMA IMG Network. Serving on the Committee were (l to r): Edgar P. Balcueva, MD; Pramilla Sinha, MD; Lourdes B. Andaya, MD, who chaired the Committee; and Abd A. Alghanem, MD.



B. Srinivasan, MD, (right), a delegate for Saginaw County and member of the MSMS IMG Section Governing Council, argued for the establishment of an AMA IMG Section rather than a network. Listening to his points was IMG Governing Council member Timothy B. Aiken, MD.



One reference committee heard testimony on the Section's 16 resolutions. Serving on the Committee were (l to r): R. Bart Sangal, MD; John Maurer, MD; Henry Forsyth, MD; C. Peter Fischer, MD. Not shown is Michael J. Parks, MD, who served as chair.



MSMS Board Chair Peter A. Duhamel, MD, served double duty at the Joint Section Meeting. He attended the HMSS portion as representative for Crittenton Hospital, Rochester.



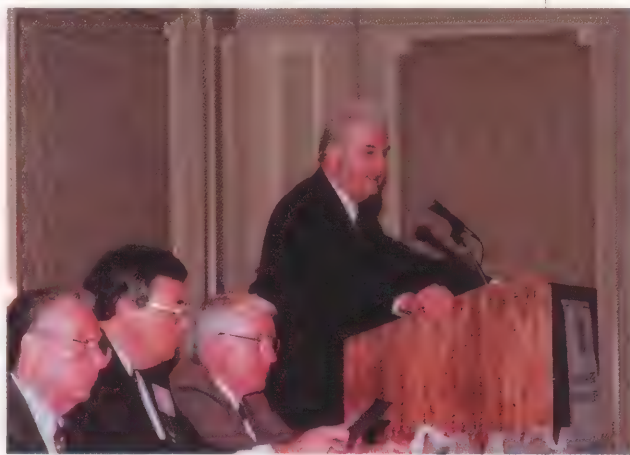
Approximately 35 Hospital Medical Staff Representatives attended the 12th HMSS Assembly in Dearborn.

Hospital Medical Staffs

The MSMS Hospital Medical Staff Section debated 16 resolutions on issues ranging from the establishment of an MSMS Physician Services Organization to managed care gag rules. Also discussed was an amendment to the Section's bylaws which would change the Section's name to Organized Medical Staff Section.



Arnold M. Cohn, MD, (far right), served as an advisor to the HMSS 12th Assembly, which met as a committee of the whole. Doctor Cohn is a member at-large of the HMSS Governing Council.



John A. Rupke, MD, (at podium), delivered the delegate's report to HMSS representatives as other members of the Governing Council listened on. Shown sitting (l to r): Arnold M. Cohn, MD, member-at-large; Edward J. Rutkowski, MD, chair; and John H. McLaughlin, MD, vice-chair.

Young Physicians

MSMS Young Physicians Section delegates and alternate delegates discussed nine resolutions at the MSMS Joint Section Meeting. Of critical importance to the Section was Resolution 1-96YPS, which calls for MSMS to survey all young physicians to determine how best organized medicine can address their concerns and needs.



Young physician delegates and alternates gather in Dearborn to debate the nine resolutions brought before the Section. During reference committee deliberations, Carol van der Harst, MD, YPS chair, took to the podium to show her support for the development of a young physicians survey.



MSMS YPS Chair Carol van der Harst, MD, discussed the activities of the YPS Section over the past year in her report to YPS delegates and alternates.

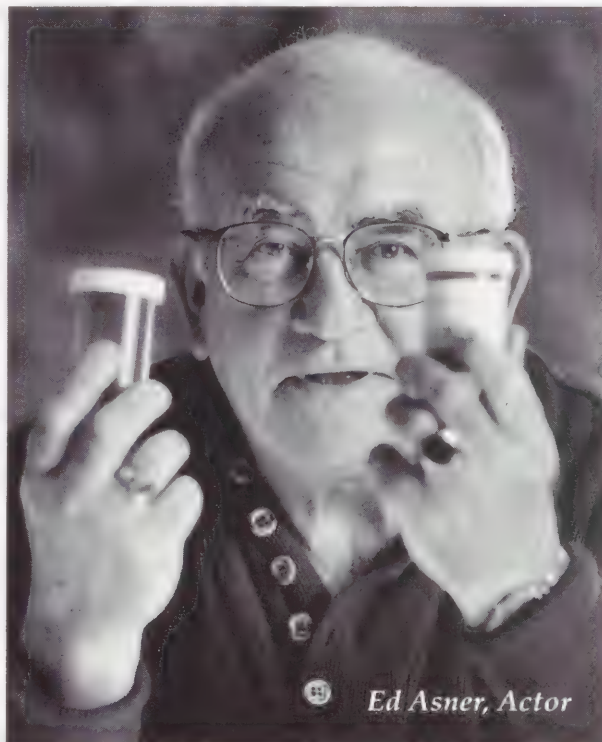


MSMS YPS Chair Carol van der Harst, MD, (right), and YPS Past Chair Tama D. Abel, MD, (left), shared their thoughts on the challenges facing young physicians with AMA Board Trustee Regina M. Benjamin, MD, who is the first to hold a young physician designated seat on the AMA Board.



Michael Workings, MD, a delegate from Wayne county, listened intently to testimony given at the YPS annual meeting in Dearborn.

Attention: Physicians



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Unity Means Power

Nothing rings more true for physicians than this

By Louis R. Zako, MD

Dear Doctor Wilson:
I do not intend to renew my membership in MSMS for the following reason: Nothing personal, but there are too many medical societies and they pose a drain of time and finances. I made the choice to focus my efforts on one medical society, my specialty society at the national level. Therefore, I have dropped my memberships in MSMS, my county medical society, my specialty society at the state level and the AMA.

*Sincerely,
 Anonymous, MD*

The above statement was received by MSMS last year when the Society asked members to explain why they had not renewed their medical society membership. Indeed, it's easy to see that this could have been written by a physician in any specialty. I dare say if all physicians shared this individual's sentiments, we would very quickly find ourselves without a unified voice for organized medicine in Michigan.

Organized medicine and MSMS grew out of common experience and the need to discuss problems - problem cases, referral opportunities, professional discipline, peer review. It also grew out of a general desire among physicians to establish friendships with one another.

Local representation crucial

On the local level, the need arose for one organization to represent physicians — not as technicians applying a skill; not as traders hawking potions or counsel; not as one of the many subdivisions and subsections of medicine; but as doctors, the central figure and purveyor

of health care in our state.

Without a doubt, a statewide physicians' organization can do more to directly influence the health status of the state than any of the specialty associations presently organized in Michigan. Socioeconomic, legislative, personnel, training, and basic health care issues apply similarly to all physicians in all specialties in a given geographic area.

We physicians in Michigan need an organization to represent us, **all** of us, regardless of the manner in which we provide

health care to our patients. Such an organization could arise by a government or physician mandate. In truth, the present form is that of a volunteer organization, which makes the most sense.

Recruitment a top priority

Because MSMS is a volunteer organization, we must concern ourselves with the question of how to recruit members. Presently, MSMS

recruits members using a number of different methods year-round. Let's take look at some of these methods.

Medical students engage in an intense peer-to-peer recruitment campaign each year. MSMS and the

county medical societies—combined with the AMA—offer a four-year membership for first-year medical students. MSMS has offered this program for the last four years, and it has increased our student section tremendously. MSMS is now considering a similar package for residents and hopes to have the program in place by next fall.

MSMS sends direct mail solicitations to

**"Light is the task when
 many share the toll."**

—Homer, Iliad

"Without a doubt, a statewide physicians' organization can do more to directly influence the health status of the state than any of the specialty associations presently organized in Michigan"

nonmembers and targets international medical graduates, women physicians and young physicians at least three times a year. MSMS also solicits newly licensed physicians who enter the state.

This year, MSMS and two county medical societies—Ingham and Wayne—have offered three-month trial memberships to 99 physicians. The trial membership allows the nonmember to receive MSMS and county medical society publications and to see firsthand what organized medicine in Michigan is doing for them.

MSMS has also solicited nonmembers after each “Making the Rounds” program. If you have not had an MTR at your hospital, please consider it. The MTR provides an excellent opportunity for physicians to have direct contact with MSMS leaders and staff. The response to our MTR’s has been wonderful. Since the program’s inception, MSMS has visited 36 hospitals and thousands of physicians throughout the state.

MSMS has also begun to receive membership requests via our MSMSNET—our gateway to the Internet—which is an amazing new benefit of

MSMS membership. Through the end of February, the MSMS home page has had 2,579 “hits.” There have been approximately 19,510 hits to other MSMSNET pages during the same time period.

An aggressive retention campaign is also employed each year when members are dropped for nonpayment of dues. From the “empty Medigram” to phonathons, MSMS contacts each dropped member to solicit the reason for nonpayment. This has certainly helped MSMS membership, which has grown at a rate of five percent over the past five years.

Fall campaign in the works

This fall, MSMS will begin a competitive “peer-to-peer” recruitment campaign and I hope you will consider becoming involved. Organized medicine enables us to speak with a unified voice, which, needless to say, is crucial in today’s competitive health care environment. ■

Doctor Zako is chair of the MSMS Committee on Membership Recruitment and Retention.

Considering affiliation opportunities and contracts?

We can help.

MSMS’ Physician Organization and Management Services consultants can arm you with information and smart strategies for this rapidly changing environment. Call Tom Wolff at (517)336-5740, or send E-mail to twolff@msms.org



Michigan State Medical Society
the Voice of 12,000 Michigan Physicians

Donald H. Huldin, MD

Fond memories of a not-so-fond place

By William Kendy

For many people who journey to San Francisco, a trip to Alcatraz is often a must. A cold, empty shell where hardened criminals once lived, visitors frequently find the experience eerie and unsettling.

It seems ironic, then, that for Donald Huldin, MD, a Lansing dermatologist, the mere mention of Alcatraz conjures some of his most fond memories.

"I can remember sitting at Alcatraz at twilight (back in 1960), eating cracked crab, sourdough bread and drinking wine, watching San Francisco light up," he says. "It was like being in fairyland, listening to the sound of the churning waves, feeling the wind and seeing the lights twinkle in the distance. It was absolutely beautiful."

A stint in the U. S. Public Health Service in 1960 led Doctor Huldin to a tour of duty in San Francisco. His responsibility: to take care of foreign seamen, the coast guard and the prisoners of Alcatraz.

"My duty as one of the general medical officers was to provide general medical needs to the inmates," says Doctor Huldin. "At that time, there was a law in

California that stated only a physician could start any IVs when drawing blood from prisoners."

To assist in these duties, Doctor Huldin had two inmate assistants: a Japanese murderer and Toledo Jim, an escape artist from Toledo, Ohio.

"These two assistants accompanied me wherever I went in the prison," he says. "They basically sheltered me from the prison population."

"One time I had a prisoner try to attack me," recalls Doctor Huldin. "Jim picked him up and threw him to the ground, and started twisting

his arm. I was concerned he would break it. I said, 'Don't do it, I'll have to fix it.'"

According to Doctor Huldin, even though the prisoners were isolated on a literal rock in the middle of San Francisco Bay,

their intelligence network was extensive.

"When I arrived for my first duty there to meet with my assistants, the inmates knew everything about me; where I was born, where I was raised, where I went to college, they knew about my family, everything about me," says Doctor Huldin.

Since Alcatraz was a working, hard labor prison, the inmates would find all kinds of ways to get out of work and get extra benefits. Giving blood and self inflicted injuries were two ways.

"Prisoners always gave blood," says Doctor Huldin. "If they gave blood, they received two packs of dried rotten Camel Cigarettes that the Red Cross had sold to the troops in the South Pacific during World War II. They had no work for the day and received a free lunch."

"Around any holiday, many prisoners would go into depression. They would steal a spoon, gradually flatten it and get a piece of wood that fits the spoon and sharpen it to a razor sharp point," he recalls. "If they got depressed, they would cut their Achilles tendon. They knew three things would happen. They would get sewed up, have a cast put on and be placed into solitary detention for six weeks. That meant they didn't have to do any hard labor."

"They also knew that if sometime during their detention they broke the cast, they would get another six weeks of detention," he adds. "How would they do it? By banging their casts on the troughs at the bottom of the walls," says Doctor Huldin. "Visit any of the prison's detention rooms today and you will see proof of this activity. There are big gouges at the bottoms of the walls."

Closer to home, Doctor Huldin also spent time administering to the inmates of Jackson State



Prison. He found similarities in both institutions.

"It's like marching back in time," says Doctor Huldin. "Both facilities are old, with the same type of construction and big steel bars."

Hailing from Muskegon, Doctor Huldin came from a long line of osteopaths and is the only MD in his family. He practiced in San Diego ("I had California in my blood"), then returned to Michigan where he started a practice in Jackson. After seven years, he decided to move his practice to Lansing. In addition to running his private practice, Doctor Huldin became a consultant to Lansing General Hospital, now known as Michigan Capital Medical Center.

"When I first came to Lansing in 1971, I was invited to be a DO consultant to Lansing General Hospital," says Doctor Huldin. "I was the first MD on staff."

Doctor Huldin is an associate clinical professor at the MSU College of Human Medicine. He has taught internal medicine and family practice residents for the past 22 years.

In his spare time ("of which I have little"), Doctor Huldin invents disposable surgical instruments for outpatient therapy and surgery. In addition, he enjoys golf, vacationing at his cottage in Harbor Springs, and singing in his church choir. He also sings for a barbershop chorus which is a member of the Society for the Preservation and Encouragement of Barbershop Quartet Singing in America. The chorus donates time and money to help treat people with hearing and speech defects and dyslexia.

"Our group's motto is, 'we sing so that they may speak.'" ■

The author is a Holt, Mich.-based freelance writer.

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Newsmakers

Steven R. Geiringer, MD, medical director of Outpatient Physician Services at Rehabilitation Institute of Michigan (RIM), is one of the best doctors in America. So say his peers who selected him to appear in the first edition of *The Best Doctors in America: Midwest Region* (1996-1997). Doctor Geiringer is an associate professor at Wayne State University School of Medicine. He remains active in medical education locally and nationally with emphasis on the diagnostic and non-operative treatment of acute musculoskeletal injuries related to occupational medicine, sports and performing arts.

Manuel Valdivieso, MD, is the newly-named director of the Oakwood Healthcare System's Cancer Center for Excellence. Within the Oakwood system, he will oversee the continuum of cancer care ranging from prevention, screening and early detection to treatment of advanced disease. Prior to accepting this post, Doctor Valdivieso was director of the Division of Hematology and Oncology at Wayne State University (WSU), and was director of the Multidisciplinary Lung Cancer Program at WSU and the Detroit Medical Center.



B. Babu Paidipaty, MD, a inter-



nist and director of critical care medicine at St. Mary Hospital, Livonia, is the Hospital's new chief of staff. Other new of-

ficers include: **Martin Daitch, MD**, of West Bloomfield, who is the new chief of staff-elect; **Vellore Ramakrishnan, MD**, of Bloomfield Hills, who is the new secretary/treasurer; and **Derek DeSouza, MD**, and **Vali Orandi, MD**, both of West Bloomfield, who are new members at large of the Executive Committee.

Bal K. Gupta, MD, is the newly-appointed chief of psychiatry at Macomb Hospital Center. Doctor Gupta previously served on the medical staff at Harper Hospital, Detroit, and also ran a general psychiatry practice for 18 years.

John P. Papp, MD, is the new president of the Kent County Medical Society. A gastroenterologist, Doctor Papp is associated with Grand Valley Internal Medicine Specialists. Other new KCMS officers include: **David M. Krhovsky, MD**, president-elect; and **Mark T. Spoolstra, MD**, who will serve a three-year term as a director. **John R. Maurer, MD**, has been re-elected to the Board of Trustees of the Kent Medical Foundation. ■

Deaths

Arthur L. Tuuri, MD, a highly-respected Flint pediatrician, died January 29 at the age of 75. He left behind him a lifetime of accomplishments. Doctor Tuuri came to Flint in 1948 to direct the Mott Children's Health Center. Under his direction, the facility became a global model for treating children's physical and social needs. After retiring from the Center in 1985, Doctor Tuuri remained active in the community, serving until 1990 as president of the Flint Area Health Foundation, which later became the Community Foundation of Greater Flint. Doctor Tuuri was a graduate of the University of Michigan Medical School.

Alexander Walt, MD, one of the country's most distinguished physicians, died February 29 of cancer at his home in Huntington Woods. He was 72. Doctor Walt, former chair of the department of surgery at Wayne State University School of Medicine and director of the Barbara Ann Karmanos Comprehensive Breast Center, was internationally known and respected for his expertise in trauma and general surgery. Born in Cape Town, South Africa, Doctor Walt received his medical degree from the University of Cape Town in 1948 and completed his training at the Royal College of Surgeons, London, and at the Mayo Clinic, Rochester, Minnesota. ■

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Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beta-blocker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

Increased Angina and/or Myocardial Infarction: Rarely, patients, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angina or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawal: When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of nifedipine treatment will not prevent this occurrence and on occasion has been reported to increase it.

Congestive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning nifedipine. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of nifedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of ADALAT CC is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg, 12% at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought to be associated with vasodilation of dependent arterioles and small blood vessels and not due to left ventricular dysfunction or generalized fluid retention. With patients whose hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Information for Patients: ADALAT CC is an extended release tablet and should be swallowed whole and taken on an empty stomach. It should not be administered with food. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted. The relationship to nifedipine therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms; however, cholestasis with or without jaundice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it rarely resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum uric acid, glucose, cholesterol or potassium.

Nifedipine, like other calcium channel blockers, decreases platelet aggregation *in vitro*. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some nifedipine patients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated. Positive direct Coombs' test with or without hemolytic anemia has been reported but a causal relationship between nifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although nifedipine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some.

Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been occasional literature reports suggesting that the combination of nifedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with cardiovascular disease.

Digitalis: Since there have been isolated reports of patients with elevated digoxin levels, and there is a possible interaction between digoxin and ADALAT CC, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

Coumarin Anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

Cimetidine: Both the peak plasma level of nifedipine and the AUC may increase in the presence of cimetidine. Ranitidine produces smaller non-significant increases. This effect of cimetidine may be mediated by its known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of nifedipine. If nifedipine therapy is initiated in a patient currently receiving cimetidine, cautious titration is advised.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy Category C. In rodents, rabbits and monkeys, nifedipine has been shown to have a variety of embryotoxic, placental and fetotoxic effects, including stunted fetuses (rats, mice and rabbits), digital anomalies (rats and rabbits), rib deformities (mice), cleft palate (mice), small placentas and underdeveloped chorionic villi (monkeys), embryonic and fetal deaths (rats, mice and rabbits), prolonged pregnancy (rats; not evaluated in other species), and decreased neonatal survival (rats; not evaluated in other species). On a mg/kg or mg/m² basis, some of the doses associated with these various effects are higher than the maximum recommended human dose and some are lower, but all are within an order of magnitude of it.

The digital anomalies seen in nifedipine-exposed rabbit pups are strikingly similar to those seen in pups exposed to phenytoin, and these are in turn similar to the phalangeal deformities that are the most common malformation seen in human children with *in utero* exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADALAT CC in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive patients. Atenolol 50 mg once daily was used concomitantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

The most common adverse event reported with ADALAT[®] CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily and 29% on ADALAT CC 90 mg daily versus 10% on placebo.

Other common adverse events reported in the above placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Fatigue/asthenia (4%, versus 4% placebo incidence); Nausea (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Body as a Whole/Systemic: chest pain, leg pain. **Central Nervous System:** paresthesia, vertigo. **Dermatologic:** rash. **Gastrointestinal:** constipation. **Musculoskeletal:** leg cramps. **Respiratory:** epistaxis, rhinitis. **Urogenital:** impotence, urinary frequency.

Other adverse events reported with an incidence of less than 1.0% were:

Body as a Whole/Systemic: cellulitis, chills, facial edema, neck pain, pelvic pain, pain. **Cardiovascular:** atrial fibrillation, bradycardia, cardiac arrest, extrasystole, hypotension, palpitations, plebeitis, postural hypotension, tachycardia, cutaneous angiectases. **Central Nervous System:** anxiety, confusion, decreased libido, depression, hypertonia, insomnia, somnolence. **Dermatologic:** pruritus, sweating. **Gastrointestinal:** abdominal pain, diarrhea, dry mouth, dyspepsia, esophagitis, flatulence, gastrointestinal hemorrhage, vomiting. **Hematologic:** lymphadenopathy. **Metabolic:** gout, weight loss. **Musculoskeletal:** arthralgia, arthritis, myalgia. **Respiratory:** dyspnea, increased cough, rales, pharyngitis. **Special Senses:** abnormal vision, amblyopia, conjunctivitis, diplopia, tinnitus. **Urogenital/Reproductive:** kidney calculus, nocturia, breast engorgement.

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergic hepatitis, alopecia, anemia, arthritis with ANA (+), depression, erythromelalgia, exfoliative dermatitis, fever, gingival hyperplasia, gynecostasia, leukopenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.


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6/95

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Pharmaceutical
Division

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Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: James E. Byers, DO, Hackley Community Care Center, 2700 Baker, Muskegon, MI 49444

Action, Date Taken: License Suspended-6 months & one day, 02-05-96

Reason: Substance Abuse

Name: Gayl M. Godsell-Stytz, DO, 2710 Dixie Highway, Waterford, MI 48328

Action, Date Taken: Limited License, Probation-2 years, 02-01-96

Reason: Drug Diversion

Name: Walayat Khan, MD, 317 Ecorse Rd., Suite 5, Ypsilanti, MI 48198

Action, Date Taken: License Suspended-3 years, Fine-\$5,000, 01-10-96

Reason: Criminal Conviction-Insurance Fraud

Name: Peter P. Krenitsky, DO, Bi-County Community Hospital, 13251 E. Ten Mile Rd., #100, Warren, MI 48089

Action, Date Taken: Probation-18 months, 02-05-96

Reason: Criminal Conviction - Alcohol Related

Name: Clarence McRipley, Jr., MD, 989 University Drive #101, Pontiac, MI 48342

Action, Date Taken: Probation-2 years, Fine-\$2,500, 02-15-96

Reason: Drug Related

Name: Mark A. Menestrina, MD, Walk-In Medcenter, 29829 Telegraph Rd., Southfield, MI 48037

Action, Date Taken: Probation-1 year, 08-28-95

Reason: Substance Abuse

Name: Seldon R. Nelson, DO, 1504 E. Grand River Ave., East Lansing, MI 48823

Action, Date Taken: Reclassified w/Unlimited License, 01-11-96

Reason: None Given ■

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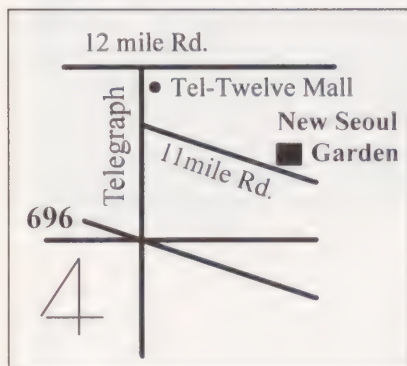
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Rural Communities and HIV/AIDS

Conference

May 15, 1996

Grand Traverse Resort, Traverse City

HIV/AIDS has made its way into rural areas and small towns across the country. This growing presence poses a number of new challenges and concerns for health care providers. The Michigan State Medical Society will address many of the concerns confronting health care providers in rural areas of Michigan during a conference titled, "Rural Communities and HIV/AIDS."



*Keynote speaker
Abraham Verghese, MD,
author of "My Own
Country: A Doctor's
Story," will share his
experiences of providing
HIV/AIDS care in rural
Tennessee.*

This full-day conference will focus on issues including the challenges of providing HIV/AIDS care in rural settings, case management, and legal considerations related to HIV/AIDS. Concurrent sessions will discuss clinical care and medical care issues. And, a panel of persons living with HIV/AIDS will talk about their experiences and challenges they face.

The registration fee for this conference is \$100.
For information, or to register, please call MSMS at (517) 336-5776.

Financial Supporters and Meeting Planning Committee:

Blue Cross Blue Shield of Michigan
Michigan Department of Public Health
Michigan State Medical Society
Thomas Judd Care Center
Michigan AIDS Fund
MSU Extension

Metro Health Foundation
MSU AIDS Education Project
Michigan Center For Rural Health
Michigan Health Council
Michigan Home Health Association
Michigan Health & Hospital Association



Michigan State Medical Society
the Voice of 12,000 Michigan Physicians

MSMS Meetings

April

26, MSMS Regional Scientific Meeting. Location: Dearborn. Contact: Sarah Cressman at MSMS at (517) 336-5727.

26-28, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: Donna Brown at (517) 336-5735 or Jeanne Miller at (517) 336-5726.

26, 28, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn. Contact: William E. Madigan, Executive Director, at (517) 336-5734.

29-May 1, MSMS Alliance House of Delegates Meeting. Location: Park Place, Traverse City, MI. Contact: Jennifer Anibal at MSMS at (517) 336-7595.

May

15, Rural Communities and HIV/AIDS. Location: Grand Traverse Resort, Traverse City, MI. Contact: Tom Seely at MSMS at (517) 336-5770.

20, Health Education Foundation Fourth Annual Golf Classic. Location: Country Club of Lansing, Lansing, MI. Contact: Dawn Reha at MSMS at (517) 336-7571.

22, 1966 Capitol Check-Up Day. Location: Lansing, MI. Contact: Donna LaGosh at MSMS at (517) 336-5788.

AMA Meetings

June

23-27, AMA House of Delegates Annual Meeting. Location: Chicago Hyatt, Chicago, IL. Contact: Judy Marr at MSMS at (517) 336-5744.

Michigan Specialty Society Meetings

April

26-28, Michigan Society of Medical Assistants Convention. Contact: Caroline Kimmel at (517) 336-7587.

May

1, Michigan Dermatological Society. Location: Henry Ford Hospital. Contact: Jennifer Anibal at (517) 336-7595.

1-3, Michigan Society for Respiratory Care Annual Meeting. Location: Dearborn, MI. Contact: Caroline Kimmel at (517) 336-7587.

3-4, Michigan Society of Internal Medicine Spring Meeting. Location: Southfield, MI. Contact: Caroline Kimmel at (517) 336-7587.

15, Michigan Allergy & Asthma Society. Location: University of Michigan. Contact: Jennifer Anibal at (517) 336-7595.

June

30-July 3, Michigan Medical Group Managers Association-Midwest Section Meeting. Location: Traverse City. Contact: Andy Lott at (517) 336-7589.

July

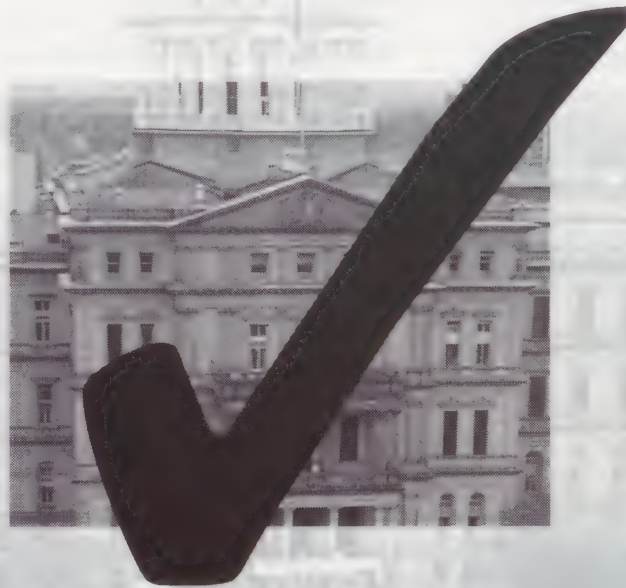
25-28, Michigan Ophthalmological Society Summer Conference. Location: Mackinac Island. Contact: Andy Lott at (517) 336-7589. ■

You are cordially invited to attend...

...the 1996 Michigan State Medical Society/
Michigan State Medical Society Alliance/
Michigan Medical Group Managers Association

Capitol Check Up

Wednesday, May 22, 1996



Radisson Hotel, Lansing

Program begins at 8:00 a.m.

Lunch with Legislators on the Lawn

Meet with Legislative Leadership

\$10 per person

sponsored by

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Michigan Physicians Mutual Liability Company

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For registration information,
call Shannon Rodgers
at (517) 336-5736

Registration Deadline: May 1

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

May

7, Bar-Levav Education Association Ongoing Seminar Series "The Values and Belief System of the Therapist: Examining Their Impact on the Psychotherapeutic Process." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

14, Bar-Levav Education Association Ongoing Seminar Series "The 'Alley-Cat' Syndrome: Finding the Suffering Patient Underneath." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

21, Bar-Levav Education Association Ongoing Seminar Series "The 'Alley-Cat' Syndrome: Finding the Suffering Patient Underneath." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

28, Bar-Levav Education Association

Ongoing Seminar Series "Providing a Holding Environment for the New Patient." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

June

4, Bar-Levav Education Association Ongoing Seminar Series "Providing a Holding Environment for the New Patient." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

25-29, Internal Medicine 1996 - Advances and Controversies. **Location:** Dublin, Ireland. **Sponsor:** Mayo Clinic and the Department of Medicine, Royal College of Surgeons in Ireland Medical School. **Contact:** Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905 (800) 323-2688.

July

14-16, 10th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. **Location:** The Grand Ho-

tel, Mackinac Island, MI. **Sponsors:** The University of Michigan Medical School, Department of Radiology. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 15 credit hours in Category I of the Physician's Recognition Award of the AMA to be announced.

29-August 2, Dynamic Psychotherapy in the New Era: Possibilities and Problems. **Location:** The Given Biomedical Institute, Aspen, Colorado. **Sponsor:** American Psychiatric Association. **Contact:** Maria Gorrnick, (phone) 202-682-6145; (fax) 202-682-6102; (e-mail) MGORRICK@psych.org. ■

ONGOING

Case Studies in Environmental Medicine. **Location:** Your office/home (self-instructional monographs). **Sponsor:** The Agency for Toxic Substances and Disease Registry, Division of Health Education. **Contact:** Michele Borgialli, Michigan Department of Public Health, Division of Health Risk Assessment, P.O. Box 30195, Lansing, MI 48909, (517) 335-9647. **Approved for:** Up to 33 hours of free Category I Credits; 1 per case study.



Ischemic Heart Disease and Congestive Heart Failure 1996:

Therapy, Underutilization and Health Care Reform

Saturday, April 27, 1996

8:00 AM to 4:15 PM

Hyatt Regency Dearborn
Fairlane Town Center
Dearborn, Michigan

DISTINGUISHED FACULTY

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Program Chairman

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Craig M. Pratt, MD

Baylor College of Medicine

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Rush Medical College

Gary L. Schaer, MD

Rush Medical College

PROGRAM DESCRIPTION

The purpose of this educational symposium is to present a review of the state-of-the-art therapy for ischemic heart disease and congestive heart failure as indicated by randomized clinical trial and investigative data. In addition, issues of underutilization of proven therapies and the implications of health care reform as it applies to those therapeutic recommendations will be addressed.

PART I — ISCHEMIC HEART DISEASE

COURSE OBJECTIVES

Illustrate the survival benefit in acute myocardial infarction of thrombolytic, antiplatelet, β -blocker, and ACE-inhibitor therapy.

Discuss those antiarrhythmic agents that have no benefit or are deleterious in ischemic heart disease patients, and review the known antiarrhythmic therapies that have proven efficacious.

Review and understand appropriate indications for direct and delayed PTCA, stents, and CABG surgery in ischemic heart disease.

PART II — CONGESTIVE HEART FAILURE

COURSE OBJECTIVES

Examine the increased prevalence and incidence of congestive heart failure in North America in the 1990s and its therapy.

Explore the advantages and disadvantages of alternative therapies to pharmacologic therapy for congestive heart failure.

Demonstrate the major mechanisms contributing to death in congestive heart failure—sudden death and pump failure and address therapeutic interventions.

FOR EASY REGISTRATION, CALL 1-800-997-9796 BY APRIL 24, 1996.

THERE IS NO REGISTRATION FEE. SEATING IS LIMITED.

This program is supported by an unrestricted educational grant from Astra USA, Inc.

Accreditation

Rush-Presbyterian-St. Luke's Medical Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. Rush-Presbyterian-St. Luke's Medical Center designates this continuing medical education activity for 6 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Please watch your mail for additional information about this important and timely program.

 RUSH

Medical Alumni Reunion and Clinic Day

Saturday, May 11, 1996

CME Session
2 Credit Hours - Category I

9:30 a.m. - 12 noon

Robert Lisak, MD

Chairman of the Department of Neurology
Wayne State University School of Medicine
Diagnosis and Medical Treatment of Stroke

Ramon Berguer, MD, PhD

Professor of Surgery of the Department of Vascular Surgery
Wayne State University School of Medicine
Carotid Artery Disease and its Surgical Treatment

Fernando Diaz, MD, PhD

Professor & Chairman of the Department of Neurological Surgery
Wayne State University School of Medicine
Diagnostic and Treatment of Aneurysms and Arteriovenous

Bruce Gans, MD

Chairman of the Department of Physical Medicine & Rehabilitation
Wayne State University School of Medicine
Rehabilitative Treatment of Completed Stroke

"STROKE"



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School of Medicine

Sponsored by

WSU School of Medicine Alumni Association

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Detroit, MI 48201

313-577-3587

12:15 p.m.

Annual Alumni Association Luncheon
Student Awards

Elvis Smith Alford, MD and Nellie Corbin

Alford Memorial Scholarship Award

Dr. Morris S. Brent Award

Robert J. Sokol, MD, Dean
State of the School Report

2:00 p.m.

Tour of the School of Medicine and
Detroit Medical Center

Financial and Estate Planning Session
Information on the Internet

7:00 p.m.

Reception and Dinner Dance

Hyatt Regency Dearborn, Dearborn, MI

Presentation of the Distinguished Alumni Awards
and the Lawrence M. Weiner Awards

The rate for classified advertising in Michigan Medicine is 90 cents per word, with a minimum charge of \$50.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication. To place a classified ad, contact Bridgett Benton at (517) 336-5747; FAX (517) 336-5797

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South Lyon	2,200 s.f.
Southgate	25,500 s.f.
Troy	4,000 s.f. (2) 2,000 s.f.
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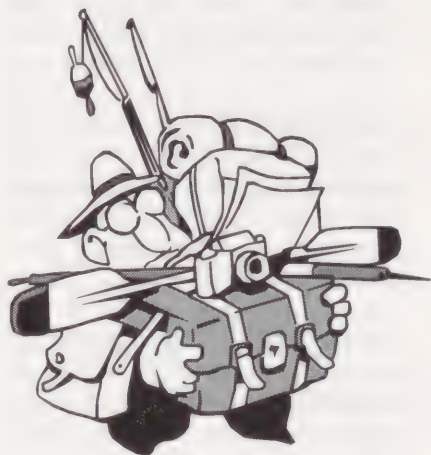
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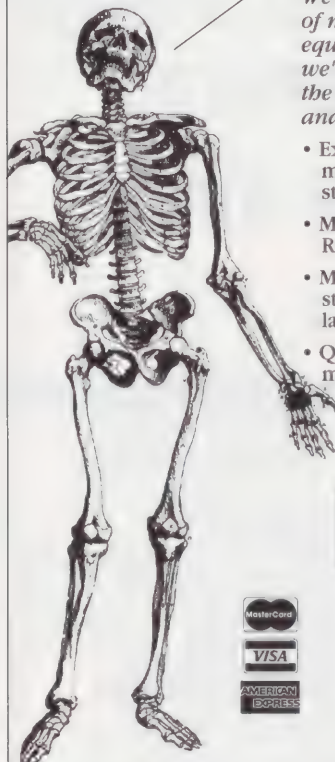
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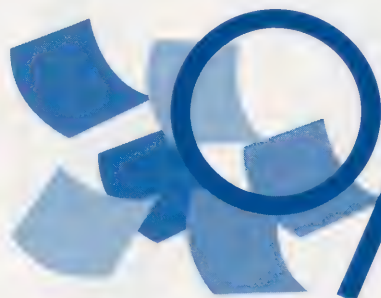
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Parting Thoughts

MSMS plays key role in the well-being of physicians

By B. David Wilson, MD

I am writing this—my last—President's Perspective during a recent trip to the American Medical Association's Leadership Conference in Washington, DC, and just prior to MSMS's public release of its Evaluation of Health Plans in Michigan.

This space in time context is important because both cause me to reflect back on my year as your president and on my "presidential theme" of physician well-being. Well-being includes taking care of ourselves, but also learning to understand and adapt to the changes being put upon us.

I began this year convinced that physicians must "work" at providing their own well-being. I leave with an even stronger conviction that physicians not only must work at well-being, but that they must work at it together through organized medicine.

Certainly, the simpler and more "intimate" aspects of physician well-being should be accomplished on your own. Protect your health. Take vacations. Do activities that you feel good about. Change your pace. Moderate bad habits.

But the big picture of physician well-being needs cooperation and participation. For example, a delegation of your MSMS leaders

pounded the halls of Congress during the recent AMA Leadership Conference in Washington, DC, trying to drum up support for anti-trust legislation and aspects of the AMA's Patient Protection Act.

We feel we were very successful, our voice was heard and we made political progress. It couldn't have been done alone. But when organized enmasse as representatives of 12,000 Michigan physicians, we were a formidable force to deal with. It is the WE of the combined efforts from county, state and specialty society leaders with the coordinating force of the AMA that expresses that ONE voice in the halls of Congress.

The same is true for the recently completed Evaluation of Health Plans. It was a massive project, requiring hundreds of committed physician and staff hours, endless frustrations and sometimes seemingly insurmountable obstacles.

But WE did it. WE have evaluated 17 Michigan health plans. WE looked at their finances, their profits, administrative costs, physician participation, utilization management and quality assurance and member service, among others. And then WE made this valuable information available to our full membership, to our patients, to the

media and anyone else who wants it to help them make decisions about health plans.

This is vital information every physician needs when dealing with the various plans, yet not one of us could have compiled it on our own. WE needed the collective resources of our professional organization, the Michigan State Medical Society, to pull it off.

This information is empowering. It gives us a leg up. It may even help reduce some of the stress we might otherwise feel if not armed with the facts. It truly is a part of the physician well-being provided to you by virtue of your membership in the Michigan State Medical Society, just one of many, many things MSMS does for you.

I don't have to tell you we are in tumultuous times professionally. But WE can make a difference. The world is run by those who show up. WE can help shape the future.

My final words:

—Participate in organized medicine.

—Keep your patients' interests paramount.

—And keep yourself well. ■

Doctor Wilson is MSMS president.

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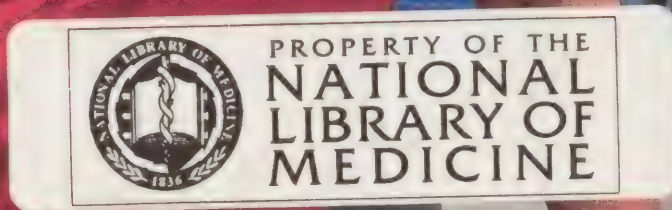
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Michigan Medicine

May 1996 • Vol. 95, No. 5

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YOUNG PHYSICIANS:

Taking charge in an era of change



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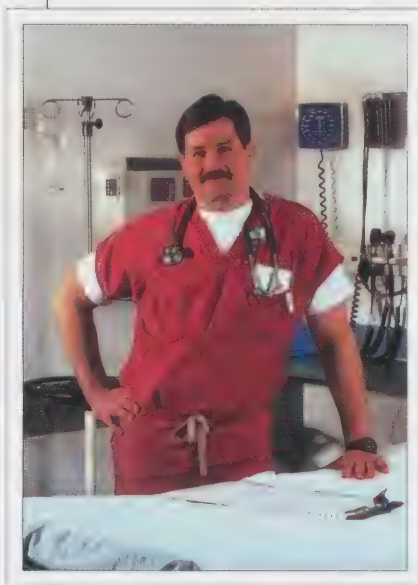
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COVER STORY



Young Physicians

27

Today's young physicians make less money, have larger work loads, suffer more stress, and have less control over their work environment than did their predecessors. So say three of Michigan's leading young physicians in this month's cover story. Also included is a "Day in the Life" account of Gregory L. Walker, MD, the newly-elected chair of the MSMS Young Physicians Section. Rounding out the cover story is an examination of the critical role young physicians play in the future of organized medicine.

By Karen Bouffard

Cover photo by: Ralph Livingston

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Evaluation of Michigan Health Plans

12

Since its March 21 release, the first-ever MSMS Evaluation of Michigan Health Plans has received extensive media coverage. This feature provides visual examples of the media coverage and discusses plans for the development and release of future evaluations.

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Managed Care

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MPMLC has taken a new approach to rate making, resulting in medical liability premium decreases in many areas of the state. This feature details MPMLC's new strategy.

By Thomas R. Berghund, MD

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Organized Medicine Needs a Tune-Up

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By Cathy O. Blight, MD

Physician Education

Maternal & Perinatal Health

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MSMS recently held its 35th Annual Conference on Maternal & Perinatal Health. Highlights of the meeting are captured in a variety of photos.



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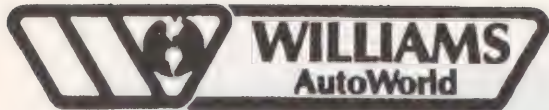
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Building Michigan's public health future.

By Karen Bouffard

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The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Clinton W. Wilson, MD, age 64
Family Physician, Benton Harbor

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John P. Quigley, MD, age 59
Pediatrician, Troy

“The most positive thing I see is that physicians are finally accountable for what they order and for how they treat patients. Prior to managed care, we weren't really accountable. Now that care is tied in with responsibility, it makes us think, and become more efficient.”

Steven R. Shapiro, DO, age 36
Family Physician, Flint

“Some standards are being created by managed care, like 'how often do you check a particular condition?' Take pacemakers, for instance. The patient may think you're a better doctor if you check them every three months, but is it really better medicine? The public too often thinks the more the doctor sees them, the better.”

Bruce G. Deckinga, MD, age 50
General Surgeon, Charlevoix

“My experience has been favorable. We have a couple thousand capitated patients at our practice, and I feel we

provide the same quality of care (for them) as (we do) with fee-for-service patients. Frankly, our reimbursement has been even higher, through a combination of good luck and good management. There are ethical considerations on quality of care, but there are ethical concerns with both models.”

Stephen G. TePastte, MD, age 49
Family Physician, Holt

“It's my sense that society desires changes in the health care system, and of all the ways this change could come about, I'd prefer the market forces of a managed care program. It produces market pressures to provide greater health care value at lower costs.”

Michael C. Tomlanovich, MD, age 51
Emergency Medicine Physician, Detroit

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490.

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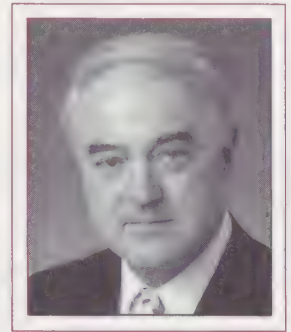
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Expert Witness Qualifications

By Richard D. Weber, MSMS Legal Counsel

Q: I was the defendant in a malpractice case some years ago and have never forgotten the testimony that was given by another physician from another part of the country. He testified that he understood the standard of practice in my community and that I violated that standard. Although I prevailed in the case, it still bothers me that this so-called expert was allowed to give such opinions to the jury. I know MSMS has achieved malpractice reform legislation. Has anything been done to stop such bogus testimony?

A: The malpractice reform legislation that became effective on April 1, 1994 requires that, if the defendant is a specialist, the expert witness must have specialized at the time of the occurrence in the same specialty. If the defendant is board certified, the witness must be board certified in the same specialty. In addition, the witness must have devoted a majority (more than 50 percent) of his or her professional time during the year immediately preceding the occurrence to either or both of the following: (1) the active clinical practice of that specialty and/or (2) the instruction in an accredited health professional school in the same health profession in which the defendant is licensed and in that same specialty. If the defendant is a general practitioner,

the expert witness must have devoted a majority of his or her professional time during the year immediately preceding the date of the occurrence to either or both of the following: (1) active clinical practice as a general practitioner and/or (2) instruction in an accredited school or residency program in the same health profession in which the defendant is licensed.

Product liability and general tort reform legislation was enacted last year. Effective March 28, 1996, additional requirements are imposed upon expert witnesses who attempt to render scientific opinions. A scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact.

Except for a small fraction of cases, plaintiffs cannot prevail in a malpractice case without presenting expert testimony on the standard of practice and its violation. Therefore, such legislation imposing restrictions on the qualifications of experts and the scientific opinions rendered is critical in defending malpractice cases.


Q: Has this legislation been upheld by the courts?

A: A case is currently pending in the Michigan Court of Appeals contesting the constitutionality of expert witness

qualifications. Although the case concerns the 1986 legislation, the constitutional ruling will create precedent for the existing legislation. The plaintiff and the Michigan Trial Lawyers Association argue in their briefs that expert witness legislation is unconstitutional under the Michigan Constitution for the reason that it impinges upon the power of the Supreme Court to establish the rules of practice in courts. MSMS has filed an amicus curiae brief in support of the constitutionality of the legislation. A decision from the Court of Appeals is expected later this year and an appeal to the Michigan Supreme Court is anticipated regardless of the ruling of the Court of Appeals.

Mr. Weber is a senior member of Kerr, Russell & Weber, PLC.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to Betty McNerney, Editor of Publications, PO Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to bmcnerney@msms.org.



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New Michigan Medicine, Medigram Formats Receive Rave Reviews

I appreciate the opportunity to comment on the redesigned Michigan State Medical Society publications. I have had a chance to review them both and commend MSMS on two very informative and well-designed publications.

I appreciate the length of articles in *Medigram*. When putting out a weekly publication, it is so important to keep the news concise and brief, while still providing enough information to allow the reader to understand the issue at hand. *Medigram*, in my opinion, accomplishes this while still keeping the copy informative and interesting.

In a similar manner, the length and detail of the articles in *Michigan Medicine* are laudatory. The articles provide ample information for the reader to gain a greater insight of the issues that are being presented, I enjoyed reading both the physician profiles and the cover story, "MSMS PSO: Providing the Crucial Link," (which appeared in the March 1996 issue).

The design, graphics and layout of both publications are impressive and your (Committee on Publications) should be congratulated on the new formats. They complement each other very well and I am sure they are being applauded by the members of the Michigan State Medical Society.

P. John Seward, MD, Executive Vice President
American Medical Association

Congratulations on the favorable revision of the Michigan State Medical Society publications. I noticed the many changes that were made to both the *Medigram* and *Michigan Medicine* and agree that they are more attractive and reader-friendly.

The stronger emphasis on human interest stories in

Michigan Medicine and the physical changes to *Medigram* are impressive improvements to both publications. The inclusion of more physician opinion pieces is also an admirable addition to *Michigan Medicine*.

I wish you the best of luck and continued success with these publications.

Lonnie R. Bristow, MD, President
American Medical Association

I like them both (*Medigram* and *Michigan Medicine*). They are clean, clear and inviting.

George D. Lundberg, Editor-in-Chief
Journal of the American Medical Association

I want to congratulate you on the new format of *Michigan Medicine*. I think it is very eye-catching and gives the appearance of being more reader friendly.

Thanks from the MSMS Alliance for all your support this year. We appreciate all the space in your publication given to Alliance articles this year!

Jean Howard, President
Michigan State Medical Society Alliance

Medigram in its expanded version is terrific. The ability to get substantial amounts of information out to physicians on a weekly basis provides current readable ammunition to them. I believe that the way that *Medigram* is laid out is much more readable than it was in the past. The expanded articles are certainly more informative. It is of much more use to me than the old version. I also like the use of pictures to draw one in to the articles.

Michigan Medicine is a work of art. I find it somewhat

Express your point of view in *Michigan Medicine*.

To submit a letter, mail, fax, or e-mail it to *Michigan Medicine*, 120 W. Saginaw St., East Lansing, MI 48823; fax (517) 337-2490; or e-mail jmarr@msms.org. Please type letters you submit for publication. Letters are published at the discretion of the editor and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Michigan State Medical Society.

frustrating to see it in its new format, because it is something that a (County Medical Society) can't aspire to in terms of physical beauty. It is wonderful to see the color cover photos like the March, 1996 edition. The pages are airy, and the color is used well to draw the reader into each article.

The layout of many of the articles and use of white space is a lot of fun. I don't think there is any question that Michigan Medicine and Medigram are potential prize winners. The MSMS Committee on Publications is to be commended as, of course, is the staff, for doing such wonderful work.

Peter A. Levine, MPH, Executive Director
Genesee County Medical Society

Both Michigan Medicine and Medigram are vastly improved. The big difference to me is in the use of pictures and shorter articles. Pictures attract the eye much faster than text and they're a lot more interesting. Time is of the essence and the shorter articles with catchy headlines are great for quick reading.

Great Job!

Terry Walsh
Stratton, Cheeseman & Walsh, Inc.

CONGRATULATIONS!! Both publications look and read great. I particularly like how bright and colorful they are and I especially appreciate the fact that the articles are much shorter in length.

We all have a lot to read every day and so when you make the articles brief and to the point, thank you.

Once again, Congratulations.

Shirley Montagne, Executive Director
Macomb County Medical Society

CORRECTION

In the March 1996 issue of *Michigan Medicine*, James E. McGillicuddy, MD, was incorrectly identified as the new chief of staff of Sparrow Hospital in Lansing. Doctor McGillicuddy is the new chief of staff *elect*. He will not assume the office of chief of staff until January 1, 1998. We apologize for any inconvenience this may have caused.

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Michigan Health Plans

*MSMS evaluation receives extensive media coverage;
Future evaluations to come*

By Mary Anne Ford

Nearly 200 people came to MSMS headquarters March 21 for the release of our first Evaluation of Michigan Health Plans. Discussion of the evaluation with physician members, hospital representatives, insurers, patient advocates, business representatives, legislators and health associations followed a morning press conference on the evaluation.

Media coverage of the evaluation was extensive, with wire service stories running in several parts of the state, nearly two pages in *Crain's Detroit Business*, a story in *American Medical News*, coverage on two Lansing television stations and coverage on Michigan Public Radio stations throughout the state.

Discussion with patient advocates during the March 21 unveiling proved especially rewarding, with several groups requesting the opportunity to work with MSMS on future evaluations. As a result of our release, several additional health plans have expressed interest in cooperating in future evaluations. The evaluation also attracted the interest of the business community; plans are now underway with General Motors for dialogue on several issues of mutual interest.

This evaluation provides MSMS with information that can be used to track trends and changes in our market. To continue the momentum from this initial report, it is vital to keep the information up-to-date, and to produce a summary of findings annually. Annual reports

are filed with the state regulatory agencies in March; a fall release of updated information will keep the evaluation current, and allow us to issue annual updates each fall.

The next evaluation will include several newly licensed HMOs. We will again invite participation from PPOs and indemnity insurers, for whom

complete information is not available from the state. At least one such entity - IBA - will be included in the evaluation, at their request.

In concert with a fall 1996 release of the updated health plan evaluation, MSMS will unveil its first evaluation of hospital financial data. ■

The author is manager of the MSMS Department on Medical Economics and Health Care Delivery.

Attending the March 21 news conference on the MSMS Evaluation of Michigan Health Plans were: Associated Press; The Detroit News; The Detroit Free Press; WKAR Michigan Public Radio; WILX Channel 10 Lansing; American Medical News; *Crain's Detroit Business*; and Booth Newspapers.



Washington budget battle creates uncertainty for Michigan programs

CLAYTON KRAMER is a New York City-based author and publisher. His books include *How to Write a Novel*, *How to Write a Screenplay*, and *How to Write a TV Series*. He is also the author of *The Art of the Novel*, *The Art of the Screenplay*, and *The Art of the TV Series*. He is currently working on a new book, *The Art of the Novel*.

Health plan survey Government says, abortion

Health plan survey

Employees' health plan preferences are changing, and employers are responding. The following table shows the results of a survey of 1,000 employees and 100 employers. The survey was conducted by the Health Research and Promotion Institute, a division of the American Medical Association.

Health Plan Feature	Desired by Employees (%)	Offered by Employers (%)
Low-deductible health plan	65	35
Health savings account	55	25
Flexible spending account	45	35
Voluntary dental plan	40	55
Voluntary vision plan	35	50
Voluntary life insurance	30	45
Voluntary disability insurance	25	40
Voluntary long-term care insurance	20	35
Voluntary critical illness insurance	15	30
Voluntary cancer insurance	10	25

Source: Health Research and Promotion Institute, American Medical Association, 2003.

[illegible]

With premiums as high as 1.5 percent, firms could drop premiums

By Kathy Burt Hoffman
Houston, Texas

Multiple health insurance programs are being dropped by firms because of the high cost of the programs, according to a survey by the National Association of Manufacturers (NAM). The survey, which was conducted in May and June, found that 15 percent of the firms had dropped their health insurance programs in the past year. The survey also found that 10 percent of the firms had dropped their dental insurance programs in the past year. The survey also found that 10 percent of the firms had dropped their vision insurance programs in the past year. The survey also found that 10 percent of the firms had dropped their life insurance programs in the past year. The survey also found that 10 percent of the firms had dropped their disability insurance programs in the past year. The survey also found that 10 percent of the firms had dropped their long-term care insurance programs in the past year. The survey also found that 10 percent of the firms had dropped their other insurance programs in the past year.

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Medicine, Medicine

Michigan health plans financially healthy, study finds

[illegible]

...and the ...

...are the profession.

† *Table 11* presents the estimated regression coefficients for the dependent variable *governance* (see Table 10 for the full regression equation).

Response for high pregnancy

For the high pregnancy group, the mean age was 32.5 years (range 25-40 years), the mean BMI was 26.5 kg/m² (range 20.5-32.5 kg/m²) and the mean gestational age at delivery was 37.5 weeks (range 34-40 weeks). The mean birth weight was 3.7 kg (range 2.5-5.0 kg) and the mean length was 49.5 cm (range 45-54 cm). The mean Apgar 1 score was 8.5 (range 7-10) and the mean Apgar 5 score was 9.5 (range 8-10). The mean duration of labour was 10.5 hours (range 6-16 hours) and the mean duration of pushing was 1.5 hours (range 0.5-3 hours). The mean duration of hospital stay was 3.5 days (range 2-5 days). The mean cost of delivery was £1,200 (range £800-£1,600).

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MPMLC Reduces Premiums

New rate-making approach benefits many policyholders

By Thomas R. Berglund, MD

Michigan Physicians Mutual Liability Company (MPMLC) has taken a new approach to rate making, resulting in medical liability premium decreases in many areas of the state.

The new approach -- based on rating each specialty separately according to claims experience and then adjusting by area -- ensures the most competitive and accurate rates. It minimizes the spread of risk across specialties, preventing lower-risk specialties from subsidizing higher-risk specialties. MPMLC is the first Michigan-based insurer to use this superior approach.

Usually, insurers categorize several specialties together in a handful of "classes." For example, a typical class of low-risk physicians may include allergy, dermatology, hematology, and pathology. This approach assumes similar risks among the specialties in the class. We've found that specialties no longer fit neatly into a handful of classes.

MPMLC decided to use specialty-based rating for three key

reasons:

First, as the market leader and as the state's only MSMS-endorsed liability insurer, we believe it's important to be the first to initiate policies that promote competitive and fair rates. As a physician-owned and operated company, we believe our primary mission is to provide the *best value* in the marketplace—across all specialties.

Second, it became clear that rating by specialty is fairer and more accurate. Using the class grouping approach, additional classes had to be created periodically for specialties that didn't fit into established classes. This suggested to us that specialty-based rating was the ideal approach.

Third, it allows MPMLC to be more responsive to the market by providing competitive rates. In a competitive market, specialty-based rating allows us to adjust the rates of one specialty (either up or down, depending on risk changes) without affecting other specialties at the same time.

While specialty-based rating is more cumbersome to administer (rates must be calculated for 96 specialty variations as opposed to only 14 class groupings), the market demands it and our physicians deserve it. No longer does one size fit all. Specialties are demanding customized policies and liability limits. Customized products, limits, and packages for all. We see this as a necessity for a company that is responsive to its customers.

Will your rates go up or down this year? Overall, the rating picture is bright for Michigan in 1996. We think you'll be pleasantly surprised with the new rates. Most specialties will see a reduction—some a substantial decrease. The premium for each specialty is set according to Michigan claims trends within each specialty.

MPMLC also narrowed the difference between the basic \$100,000/\$300,000 limits and the more attractive \$200,000/\$600,000 limits. It may be time for you to take advantage of higher limits. More than 60 percent of physicians choose \$200,000/\$600,000 limits or higher.

What is the net result of our new rating approach? More accurate rates. Rewards for effective risk management. Lower rates for many specialties and competitive rates for all specialties. Accountability by specialty. Market responsiveness. And fairness, fairness, fairness.

If you'd like more information about rates in your area, please contact the Stratton, Cheeseman & Walsh agency at 1-800-968-4929.

Doctor Berglund is president and chair of MPMLC.





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Organized Medicine Needs a Tune-up

AMA a good place to start

By Cathy O. Blight, MD

Next month, the Midwest will play host to one of the most important strategic planning missions for the future of organized medicine.

It's a mission that is of paramount importance to all physicians and medical societies. It will test our willingness to prioritize the unity of the medical profession over parochial interests.

It is the mission of the Study of the Federation, which will be discussed at the AMA's June House of Delegates meeting in Chicago.

The Study of the Federation is a two-year analysis and plan designed to help navigate all levels of organized medicine through the murky waters of industry turbulence, taking into account internal evolution of, and external challenges to, the medical profession. The Study Consortium is a 250-member group that directs the project, and the Study Project Team is a 30-member subgroup that shapes the final proposal.

The Consortium has concluded that the future viability of local, state, specialty and special interest medical associations rests on proactivity to improve interorganizational communications, exploring mutually-beneficial joint ventures and enhancing the representativeness of medicine's umbrella organization -- the AMA.

And it suggests that we begin with the AMA.

One of the biggest obstacles to acting on behalf of the profession and our patients is that fewer than half of all physicians belong to the AMA. And fewer and fewer are joining.

So the Consortium has decided that the AMA House needs to be more representative and inclusive of today's physicians. Because of the importance of grassroots involvement, no changes are proposed in the State's representation. However, to accommodate the increasing influence and importance of the

specialties, one recommendation is that specialty societies get proportional representation in the AMA House to better level the playing field with the

geographical representation.

Here's how it might work. Each fall, physicians will pick one specialty society to represent them. Once ballots are tabulated, those societies will then get proportional representation in the AMA House based on these votes. (Current specialty societies will continue to hold at least one seat).

There are other suggested changes, too, to better involve physicians who may feel disenfranchised by the current configuration of the AMA House, and who are increasingly becoming more significant in medicine's profile.

Take a look at a snapshot of contemporary medicine. Women physicians are increasing in number and clout faster than any other subgroup; and graduates of international medical schools create a rich spectrum of racial and ethnic diversity by incorporating training pearls from abroad with the best that American medicine has to offer.

In addition, specialties are becoming more complex with subspecialties and super-specialties; and multiple variations on new and old models of integrated health care delivery systems are sprouting rapidly. Although we haven't yet determined the exact mechanism for increased involvement by these subgroups, we hope they will play a greater role in governance than before. We're hoping that they themselves will fashion proposals of participation for consideration by the AMA House.

And, three currently recognized national medical organizations will be assured a delegate: the American Osteopathic Association, the American Medical Women's Association, and the National Medical Association.

For anyone familiar with the AMA House, these recommendations might seem pretty revolutionary since they could dramatically shift



"... shaping the governance of the AMA to reflect the profession is only consistent with tradition."

the base of that body's power and influence. Yet shaping the governance of the AMA to reflect the profession is only consistent with tradition. It first took place in 1901 by the McCormack Committee, a group called in to submit recommendations based on the profession at that time. And the difference between then and now is striking.

At that time, physicians were a more homogeneous group - they were almost exclusively born and trained in the US; they were male; the major division was between the two specialties of general practice and surgery; and there existed one type of practice - solo.

No wonder the current configuration of the

AMA's House of Delegates has become less relevant to today's physicians. It was fashioned for a completely different era.

It is time for our umbrella organization to evolve in line with our profession. ■

Doctor Blight is a Flint pathologist and vice chair of the Michigan Delegation to the AMA.

Have an opinion about the future of organized medicine? Submit your comments to: Michigan Delegation to the AMA, Attn: Billy Ben Baumann, MD, P.O. Box 950, East Lansing, MI 48826-0950. You may also submit your comments to Doctor Baumann via fax at (517) 337-2490 or by e-mail to bbaumann@msms.org.

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Maternal & Perinatal Health

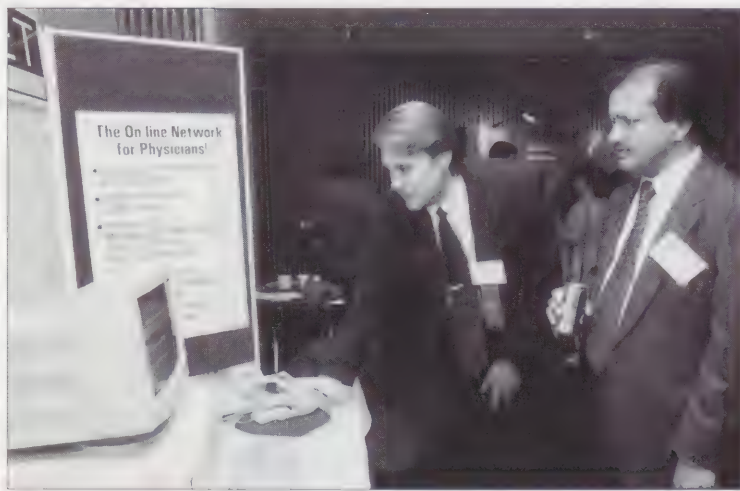
MSMS hosts 35th annual conference

Approximately 80 physicians and 144 nurses gathered in Troy March 28 for the 35th Annual Conference on Maternal & Perinatal Health. Course topics ranged from preconception counseling to the implications of shortened hospital stays for mother and baby. Following are photo highlights of the day-long conference.



Three speakers addressed conference attendees during the opening general session. They were: Robert C. Cefalo, MD, PhD, who discussed preconception counseling; Seetha Shankaran, MD, who discussed the impact of antenatal steroids on neonatal outcome; and Anne Schuchat, MD, who discussed the new CDC guidelines for Group B strep prevention.

Fifteen exhibitors displayed their products and services at the conference. Among the exhibitors was MSMSNET, the Michigan State Medical Society's on-line network for physicians. Andy Clay (left), chief of Internet systems for MSMS, explains the website to Bay City pediatrician Bilugali M. Sundara, MD.





Robert C. Cefalo, MD, PhD, professor of obstetrics and gynecology and director of maternal and fetal medicine at the University of North Carolina at Chapel Hill, discussed pre-conception counseling during the morning general session.

Paul T. vonOeyen, MD, chair of the MSMS Maternal and Perinatal Health Conference Planning Committee, welcomed attendees to the 35th annual conference.



A group of nurses took a break from the conference schedule to share their perspectives on maternal and perinatal health issues. The majority of the 144 nurses who attended the conference were from southeast Michigan.

Valerie Castle, MD, Division of Pediatric Hematology, University of Michigan Medical Center, discussed thrombocytopenia in newborns.



Mary Conklin, RN, a nurse consultant with the Michigan Department of Community Health, discussed current programming for families experiencing sudden infant death syndrome and major recommendations of the SIDS Task Force.



Patricia Klassa, RN, MSN, IBCLC, was one of a panel of speakers who spoke at the afternoon general session on the shortened hospital stay of mother and baby.

Private Label Insurance

Physician-run plans let doctors take the risk

By Karen Bouffard

A growing number of physicians are looking at alternatives to HMOs and other managed care plans that are gaining increasing control over pricing, medical decision-making and choice of provider. Seeking greater autonomy, a healthier share of the premium dollar, and ultimately better health care for patients, physicians are looking with increasing interest at accepting the risk of the cost of health care by forming physician-run indemnity insurance programs.

To learn more about physician-run indemnity programs, MSMS invited industry leaders to address the topic at a special meeting held at MSMS headquarters in late March. Invited guests included Doug Urich, executive director of The Hammond Clinic, which is one of the nation's first clinics to market a provider-driven indemnity insurance plan. Founded in 1957, the clinic's 88-physician group serves the Chicago market with a 20,000 square-foot clinical facility in Munster, Indiana, and two satellite facilities.

Also at the meeting was Doug Bushe, president of EHCDS, Inc., of Fort Wayne, Indiana, who discussed the administrative, financial and marketing systems needed by physician groups to establish a successfully run indemnity program.

David Bowen, president of Provider LINC, Inc., also of Fort Wayne, explained the market conditions and insurance relations necessary to successfully establish a private indemnity program.

A new variant of direct employer contracting

Called "private-label insurance," the plans are a new variant of "direct employer contracting" in which the employer purchases services from providers and pays them directly. What's new and different about private-label insurance is that it moves the insurance risk from the employer or

insurance company directly to the health care provider without the provider actually becoming an insurance company. This "virtual" insurance company allows providers to realize the underwriting gain that normally goes to the HMO or insurance company.

Thomas E. Stone, MD, a Muskegon urologist who attended the MSMS meeting, says he believes such plans may

be an attractive alternative to current managed care plans. "Physicians are going to have to take the risk in order to have the kind of control and influence we need," he says, adding that MSMS should take the lead by studying such alternatives and providing resources to physician groups that are interested. "Those who take the risk are going to be the ones who make the rules, because they're the ones absorbing the financial responsibility."

Urich noted, "By virtue of having 53,000 capitated lives, we were already taking the risk." The Hammond Clinic chose to market its plan to small employers with less than 200 employees, a target market underserved by local HMOs. He expects the plan, which is based on capitation with a built-in fee-for-service arrangement, to have 2,000 health care lives by the end of its first year. "The HMOs already are telling us we're doing a good job with hospital utilization, patient satisfaction and access to care. We're already doing that for the insurance companies. Why not do it for ourselves?"

Urich and the Hammond physicians have received assistance from Bushe's firm, Innovative Health Care Solutions, which is dedicated to the development and management of fully integrated, provider-owned, community-based managed care health plans. To be successful, says Bushe, such plans must achieve the optimal balance between quality, cost and access by

"Physicians are going to have to take the risk in order to have the kind of control and influence we need."

aligning incentives between patients, purchasers and providers. In addition, Bushe says, EHCDS achieves its goals by creating reimbursement arrangements that reward physicians for prudent medical and financial management of their patients, and by providing physicians and other providers with the administrative and information systems support necessary for successful medical and financial outcomes.

EHCDS facilitates the physician group in contracting with an insurance company to provide the insurance shell and plan excess insurance, and provides "insurance bureau" services including provider network management, utilization review, plan management, market and sales, managed care and financial reporting, underwriting and risk pool management and reporting.

According to Bushe, physician-run indemnity programs can achieve greater efficiency, reducing administrative costs which for HMOs can account for five to 18 percent of each premium dollar. Urich says administrative costs can be even higher for small employers' plans, up to 40 percent. He expects that, following the initial start-up, Hammond Clinic's administrative costs will range from 10 to 12 percent.

Cecil A. Jonas, MD, who also attended the MSMS meeting, says he believes physician-run indemnity programs warrant further study, and could be a good alternative to existing plans if they do indeed produce the projected administrative savings. "If we can do that, my thought it we're really competitive. But the figures used are the figures submitted to the insurance bureaus, and if you talk to the administrators they say their overhead isn't that high," he says. "If we can't do better than that, then I don't think we should be in the business of setting up physician organizations."

Another physician who attended the meeting was Louis R. Zako, MD, a Petoskey primary care physician, who says he believes physician-run indemnity programs could result in better medicine. "Not only is a doctor-driven health plan in the medical profession's best interest -- in terms of both professional autonomy and financial stability -- but more importantly, it is in the best interest of the patients. Take, for example, the case of a patient that needs an MRI of the back. If I have autonomy and I deny the patient the test, you know exactly who denied it. But if I am simply a conduit for another organization, we do you go to?"

According to Bushe, "Physicians like making their own decisions and being rewarded for that. They need to be in control of the delivery system. Hospitals don't admit anybody -- doctors do. (With private label insurance) physicians are rewarded appropriately if they do a good job. If you can present physicians with information about outcomes, they'll make changes that result in very good medicine. They will also make necessary changes on the financial side."

Also presenting at the MSMS meeting was David Bowen, FSA, president of Provider LINC, Inc., of Fort Wayne, Indiana. Provider LINC helps physician groups connect with firms such as EHCDS, and will make recommendations about insurance companies, stop-loss coverage and captive plans.

"We make sure physician groups are married up with people they're comfortable with when they're putting together a health plan. We will take them through all the steps and link them up with the appropriate partners," says Bowen. "We are like the architects and contractors. We help them design the plan. We also help them find the right people to do the plumbing, the electrical, etc."

According to Doctor Stone, physician-run indemnity programs may not be for every group, but the idea certainly warrants investigation. "MSMS should study this as another possible alternative," he says. "It's been suggested that the physicians may have an opportunity here to take back the control of health care. We seem to have lost it somewhere, and patients have lost their best advocate."

"With some of these new alternatives, we may have a better chance to influence the direction health care takes in the 21st Century."

For more information on physician-run indemnity programs, contact John Richards, General Manager, MSMS Subsidiary Operations, at (517) 337-1351. Fred Bushe can be reached at EHCDS at (219) 490-8207. David Bowen may be contacted at (219) 484-6730. ■

The author is a Williamston, Michigan-based freelance writer.



Industry leaders gathered at MSMS headquarters in late March to learn more about physician-run indemnity programs.

Michigan Medical Schools Face Cadaver Shortage

Physician input needed to educate public

By Lawrence M. Ross, MD, PhD; William E. Burkel, PhD; and Jerald A. Mitchell, PhD

The University of Michigan, Wayne State University, and Michigan State University are experiencing a shortage of cadaver specimens. All three universities rely on their donor programs to receive bodies for educational and research programs at their medical schools.

Michigan's medical schools are pledged to provide each other bodies if a school experiences a shortage. However, when all three universities have the shortage, it begins to have an adverse effect upon the ability of our three universities to provide anatomical material to hospitals

around the state for postgraduate medical and dental education programs.

Continuing Medical Education (CME) programs, workshops devoted to surgical skills and procedures, and applied clinical anatomical research projects require specimens -- which also has contributed to the shortage.

In addition, the three universities are receiving requests from current and newly-created allied health programs (physical therapy, occupational therapy, respiratory therapy, physician assistants) at many universities and colleges around the state which also require human anatomical specimens.

Donor population changing

Physicians who attended medical school 15 to 20 years ago likely studied gross anatomy from a cadaver that was an "unclaimed body" -- an individual with no known relative or friend to make burial arrangements or receive the cremated remains following the body's use in medical education. In the intervening 15 to 20 years, that has changed dramatically at almost every medical school in the United States. Today, almost every body received by medical schools has been willed or donated. Use and reliance upon unclaimed bodies by anatomy departments is declining dramatically, in part because this population generally has poor medical history data and is clearly "at risk" for conditions such as hepatitis, tuberculosis and HIV, which in turn poses a hazard to anatomy department staff who preserve the bodies.

In 1995, 99.7 percent of the bodies accepted by Michigan's three universities were willed or

This shortfall is having an adverse impact on the ability of the medical schools to provide anatomical specimens for postgraduate medical training programs and allied health programs at other universities and colleges. It is very real and nationwide, despite the perceptions of the general public derived from a recent television broadcast on ABC's 20/20 or the pronouncements of the funeral industry.

There are a variety of reasons for why this shortage has occurred: Requests for anatomical specimens have increased, and the types of programs needing anatomical material have become more diverse; the demographics of the donor population have changed; and the donor programs of the medical schools have adapted their procedures to meet these changes.

Changes are now in place in medical school gross anatomy courses in this state which address the importance of this unique gift to medical education and our insistence upon dignity and respect for the specimens. Medical students now participate in the annual memorial interment services.

Shortage real

The Willed Body Programs at Michigan State University, University of Michigan and Wayne State University each reported a shortage of approximately 20 bodies at the 1995 meeting of the Anatomy Board of the State of Michigan. This shortage of about 60 specimens for the state has not yet affected the medical and dental schools' ability to teach gross anatomy to their first year medical and dental students.

"... almost every body received by medical schools has been willed or donated. Use of and reliance upon unclaimed bodies... is declining dramatically..."

donated. In addition, there is strong media attention given to organ donation programs which are not shared by the medical schools' whole body donor programs for medical education.

Physicians partly to blame for shortage

Unintentionally, Michigan physicians have contributed to the current cadaver shortage. Through their health care expertise, the population is living longer.

Perhaps more importantly, with a longer life span, our population now has the opportunity to develop multisystem medical problems, which in the long term will make increased numbers of donors unacceptable at the time of death. These multisystem pathologies not only disturb the anatomy required for the instruction of medical and dental students, allied health students and postgraduate medical trainees, it often compromises the ability to achieve adequate long-term preservation of the body that is needed for these educational activities.

Physicians responsible for postgraduate training programs are asking our departments to respond to their needs for anatomical material to provide their residents with the very best training possible.

Finally, certain specialties are asking us to provide anatomical material for use in the development of better techniques and the enhancement of skills, especially in surgical and procedural radiology. As noted above, it is in these last two areas that we are having the greatest difficulty with adequacy of supply.

Physicians can be part of solution

We believe the most direct way we might correct this shortage problem is to ask Michigan physicians for help. Physicians can do this by keeping in mind the option of a whole body donation to the Willd Body Programs of one of our state's four medical schools. We realize that the heightened medical attention and physician awareness that an organ transplant can literally provide a critically ill patient with a second life often brings organ donation to mind first when dealing with the patient or their family. The patient's medical condition or their age may rule out organ donation, but a whole body donation for medical education is still often a viable option. Any of the three donor programs will be happy to provide you with further information about their specific programs, including informa-

tional brochures about the program which answer most of the frequently asked questions and provide the name, address and telephone numbers of the donor program office. We recognize that many Michigan physicians are alumni of, or have professional affiliations with, one of Michigan's four medical schools, and so we include for your information and convenience, the names, addresses and telephone numbers of all three Willd Body Programs. We hope you will assist us with this problem, and by doing so, help us assist Michigan citizens, and Michigan's present and future physicians. ■

Doctor Ross is from the Department of Anatomy, Michigan State University; Professor Burkel is with the Department of Anatomy & Cell Biology, The University of Michigan; and Professor Mitchell is with the Department of Anatomy & Cell Biology, Wayne State University.

Whom to Contact About Donations

Michigan State University
Ms. Kristin L. Liles
Department of Anatomy
E206 Fee Hall
Michigan State University
East Lansing, MI 48824-1316
(517) 353-5398

University of Michigan
Mr. Dean Mueller
Department of Anatomy & Cell Biology
University of Michigan Medical School
Ann Arbor, MI 48109-0616
(313) 764-4359

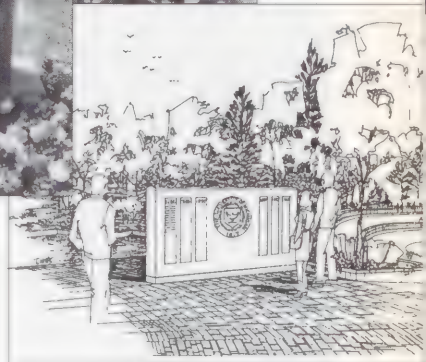
Wayne State University
Ms. Barbara Rosso
Department of Anatomy
Wayne State University School of Medicine
Gordon H. Scott Hall
Detroit, MI 48201
(313) 577-2890



Michigan State University



Wayne State University



University of Michigan

Each medical school's anatomy department has its own burial plot in which the remains of donors can be buried at the expense of the department if the donor or their family so specify.

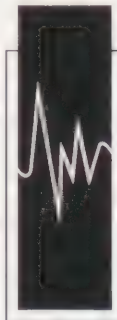
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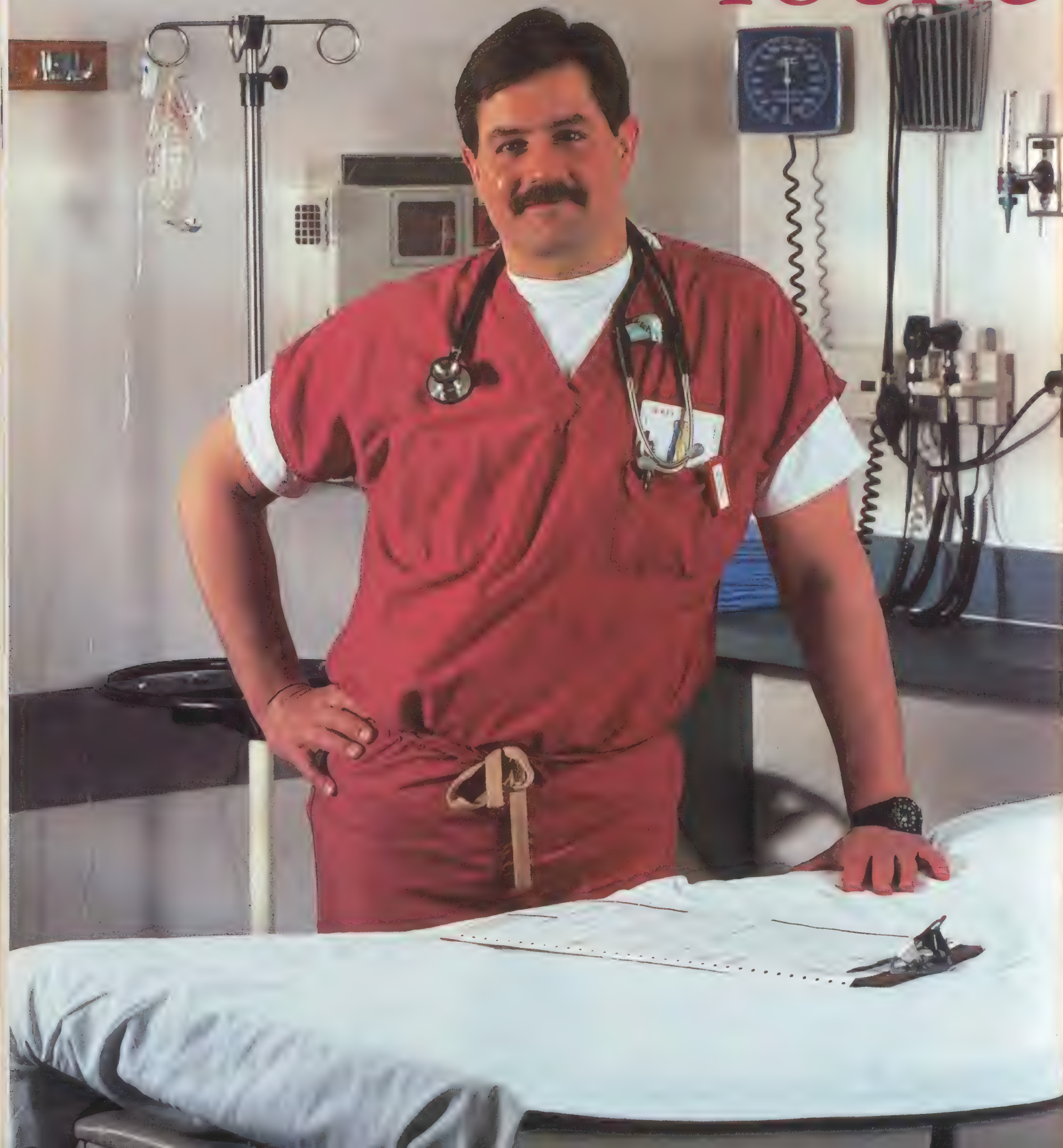
The purpose of the breast-conserving treatment is to treat these patients adequately but with a good cosmetic result. Stage for stage, patients treated in this manner have the same longevity and the same freedom from local recurrence as those treated with mastectomy.

For copies of the standards please contact Keri Sperry, American College of Radiology, 1891 Preston White Drive, Reston, VA 22091.



YOUNG PHYSICIANS:

Taking charge in an era of change



Today's young physicians make less money, have larger work loads, suffer more stress, and have less control over their work environment than their predecessors. So say three of Michigan's leading young physicians who were interviewed for this cover story. Despite these burdens, these physicians are rugged individualists who've found creative and productive ways to take charge, and they are happy they chose to become physicians. This cover story begins with their comments and insights. Also included is a compelling "Day in the Life" account of a young emergency medicine physician. Rounding out this cover story is an examination of the critical role young physicians play in the future of MSMS.

New Challenges

Young physicians strive for balance and control

By Karen Bouffard

Thousands of Michigan's doctors are struggling to maintain their autonomy in the face of managed care. They are also trying to balance their professional and personal lives. Following are their comments.



Karl Edelmann, MD

"Insurance companies are wreaking havoc with how medicine is being practiced," says Karl Edelmann, MD, 34, who runs a solo family medicine practice in Ann Arbor. "It can be very frustrating but challenging to maintain standards and stay within the managed care environment. The trend toward managed care has also meant a decrease in reimbursement to physicians. There's less reimbursement, but no decrease in liability.

"For those interested in truly caring for people, the incentive to be a physician is still strong. But there are more and more barriers put up that get in the way — limited panels, limited specialty choice, capitation, referrals, hospital requirements..."

Pino Colone, MD, 30, an emergency physician at Flint's Hurley Medical Center, talks about what it was like for him, as a young physician, when Congress was discussing the proposed health system reforms that failed to reach fruition in 1992. "There was an initial great panic," he says, "thinking that changes were going to happen and we (physicians) weren't going to be included in the process of change."

At the heart of that panic, Doctor Colone adds, was his concern for "maintaining the physician-patient relationship, and preserving doctors' autonomy with regard to medical decision-making."

Young physicians are taking control of their professional and personal lives through their business and lifestyle choices. They are also getting more involved in organized medicine in or-

der to be sure their voices are heard.

"I chose to go solo because I have some very strong ideas and ideals," say Doctor Edelmann, who started with zero patients seven years ago and now has a

practice of 9,000 patients with two physician assistants and close to \$1 million in billings. His wife, Jackie, works full-time as business manager for the practice. "From the beginning, my practice was set up on a managed care basis, rather than a fee-for-service basis. Also, at a time when most practices were not computerized, we were computerized from day one.

"Most practices referred out for everything. We don't send people to a lot of different specialists to do things I've been trained to do. I'm well-trained and continually upgrading my skills."

Carol van der Harst, MD, 39, immediate past chair of the MSMS Young Physicians Section and a Bay City psychiatrist, has structured her practice to suit her ideals. Her choice of specialty reflects her personal values.

"I enjoy the opportunity to approach patients holistically, and work with them in every area of their lives — their hopes, their goals, their family life," she says. "I love it. It's what gets me up in the morning.

"My practice is sensitive to women who work," she adds. "I hold office hours with sensitivity to the school schedule — we're closed during school holidays. I don't change my clinical schedule without consulting with all the women who work with me about their child-care needs."

Like Doctor Edelmann, Doctor van der Harst works side-by-side with her spouse. Her husband, Robert, manages her business full time. Both Doctors Edelmann and van der Harst give top priority to their families, and make a point of living healthy lifestyles. "You've just got to do it," Doctor Edelmann says.

"I've chosen never to have a housekeeper, because if I have to work five more hours a week



Pino Colone, MD

to hire one it seems the wrong priority. I would rather spend that time with my family," says Doctor van der Harst, adding that she's always included her family in her professional life. "They've always been a part of what I was doing."

Despite her busy practice, and her involvement in MSMS, Doctor van der Harst takes time to exercise daily on a NordicTrack. She also likes to cook, and prepares a wide variety of ethnic and vegetarian dishes for her family during the week. As often as possible, she combines physical recreation with family life by taking great vacations. "We take active vacations — we hike, we go cross-country skiing," she says. "Last year we spent 12 days backpacking in the Swiss Alps. I travel with my Academy or have nice weekends with my family. Our family life is a lot richer because of what medicine has allowed me."

Like Doctor van der Harst, Doctor Colone believes it is important for young physicians to

take time to get involved in organized medicine. He is a member of the MSMS Young Physicians Section, and a past chair of the MSMS Resident Physician Section. He is also active in the AMA.

"I have realized that by being involved your one voice can become policy for the organization," he says. "You can effect change by being active. We need to make sure medicine's voice is heard in the changes that are occurring in health care. Physicians must be represented."

"I want to be a part of what happens," Doctor Colone adds. "I don't want to just sit there and watch." ■

The author is a Williamston, Mich.-based freelance writer.



Carol van der Harst, MD

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A Day in the Life of Gregory L. Walker, MD

For this young physician, a Friday night in the ER is a mix of medicine and madness

By Karen Bouffard

Sparrow Hospital's emergency ward has been recently redecorated in pastel shades of pink, green and blue. Thick bullet-proof glass encases admissions personnel, who communicate by telephone with those seeking entry to the totally refurbished treatment area. Located in Lansing, the trauma center handles about 54,000 emergency visits per year. On a Friday night like this one, the ward will handle 100 or more patients. As the emergency medicine physician on duty from 3:00 p.m. till midnight, Gregory L. Walker, MD, will have contact with all of them.

This particular Friday at about 3:10 p.m., Doctor Walker has barely arrived, changed and oriented himself before paramedics arrive with the first trauma of his shift: an 85-year-old woman who stepped out in front of a car, taking out a headlight, dislodging the front bumper and denting the hood before being thrown 40 feet to the pavement. Small and frail, the patient lies naked in the trauma room while no less than 20 medical personnel assess her condition and begin life saving treatment. Doctor Walker positions himself around the perimeter of the throng where he can better take command of the several medical teams that gather around the patient, each focused on its own aspect of treatment.

A technician shouts, "X-ray!" and everyone around the narrow table drops what they're doing. They move back until the film is shot, then resume working. Back and forth from the table they move, time and again, until the patient's belly, head, pelvis and legs have been X-rayed.

Doctor Walker is no longer in the room. He's disappeared; on to the next patient. It's 3:45 p.m.

Doctor Walker, 37, has been with Sparrow Hospital's Emergency Department throughout his medical career. After graduating from MSU's College of Human Medicine in 1988, Doctor Walker completed his residency in emergency medicine at Sparrow. He has stayed on at Spar-

row since completing his residency in 1991. In March, he was elected chair of the MSMS Young Physicians Section.

Emergency medicine "suits who I am," Doctor Walker says. An avid hockey player since childhood, he was a "walk-on" for the MSU Spartans. He's now a member of the Senior Hockey League, and plays about three games per week during the season. He skates year-round.

"There's a kind of 'game day' personality to (emergency

medicine)," he says. "No two days are ever alike. There's a fun aspect to it. You go in knowing you're going to work real hard, but you never really know what you're getting into. It's like a little war almost. You have to make decisions quickly, with little information. That's the challenge: To go in and take control, and put the patient in the right direction.

"You never know what's going to happen on any given day. And the carrot at the end is that you can go home and put your feet up, and you're really done."

Doctor Walker works an average of 35 hours per week at Sparrow. For a change of pace, he also works a few days per month at Owosso's Memorial Health Care Center. "It's a drastic change," he says, noting that Memorial's volume is about half that of Sparrow's. "There is a little bit of free time there; I often eat lunch, which I rarely do at Sparrow."

"I like what I do," he says. "It's shift-work oriented. I'm on call about three times per month, but I'm rarely called in. When I'm off duty, I'm off. I can go to a hockey game in Detroit if I want to."

Doctor Walker admits that, like any other specialty, emergency medicine isn't for everyone. "Each specialty has its own personality," he says.

"Some people make their choice for the wrong reasons — maybe they think their specialty is glamorous, or maybe they want to be a surgeon because their dad was a surgeon. You have to ask yourself, 'What do I like?' If you don't, you're going to be miserable."

Doctor Walker notes that an emergency physician can't harbor a strong dislike for any particular field of medicine, "because whatever it is, you're going to have to deal with it."

"When I did my rotations in medical school, I was pretty interested in them all," he says. "Emergency medicine's a blend of all of them. You get to do a wide range of things. Also, it's pretty technical and I like the technical part of medicine — the intubating, the suturing..."

Doctor Walker also likes to teach. He's an associate clinical professor jointly appointed by MSU's College of Human Medicine and College of Osteopathic Medicine. He chose Sparrow because it has a residency program in emergency medicine. At any given time Doctor Walker directly supervises the activities of two or more emergency medicine residents, plus residents in pediatrics, family medicine and other specialties that are called in on special cases. He spends 60 to 75 percent of his time teaching.

The hallway outside the trauma room is the hub of the emergency ward. Here is the nursing station, which at any given time is occupied by as many as 15 medical and clerical personnel. Directly across from it, just next to the trauma room, is a large white marker board that is continually updated with the status of each patient.

Doctor Walker frequently glances at the status board. He also checks the counter where new charts of yet unseen patients are placed, grabbing one if he sees it. If there's not a new one, he grabs a current chart off a wall where they are hung and starts writing. Every free minute, he charts. He doesn't resent the paperwork, he says. "It's just good medicine." Other times he's waylaid by phone calls, one tonight from somebody who wants a job, several about billing, one from the hospital's risk manager, some from

consulting physicians...

Doctor Walker didn't learn about the business of medicine in medical school, he says.

"Medicine is a business, and it's not free from involvement in the other aspects of life," he says. "The business part is not something that comes naturally, like teaching or research. It's something you're not trained in, but that you have to get involved in."

Doctor Walker doesn't fault medical schools for failing to prepare doctors for the business aspects of practice. He believes residency programs can provide training to meet the demands of particular specialties.

"Medical schools have their work cut out for them just providing the medical and clinical training doctors need," he says. "The field of knowledge just gets deeper — it's never going to get shallower. Given the amount of stuff schools have to teach in four years, it would be a luxury if they could work in some business training — but not at the expense of impeding clinical training."

"Residency programs are the most appropriate place to learn about the issues that are pertinent to a specialty. They can provide training in things like how to set up a practice, or in the case of emergency medicine, put someone on a committee so they can be exposed to the hospital environment."



Doctor Walker takes a moment to consult with one of his colleagues.

Continued on following page

Continued from previous page

The most frustrating aspects of Doctor Walker's job are administrative, he says. He ponders whether the very qualities that make him a successful emergency room physician get in his way when dealing with hospital committees, red tape and bureaucracy. He's accustomed to making decisions quickly, based on limited information, and taking action. Administrative processes move more slowly. "Maybe a pediatrician would do it better," he says.

Doctor Walker sees a patient who has pain and shortness of breath. A man of about 40, the patient, softly and without emotion, fills Doctor Walker in on his history. He has cancer that has metastasized. It started in his abdomen. There are two spots on his kidney. It's in his lungs. He's never smoked. He's lost 44 pounds in 10 weeks. "I'm in my last few months now," he says. He's had no chemotherapy since July, just pain medication. He is at Sparrow to keep his wife company. She is, as we speak, in surgery for a brain tumor. Doctor Walker listens quietly while examining the patient. He orders chest x-rays and lab work. Outside the examination room he is asked, "Does this make you sad?" He answers, "Later... Now I don't have time to be sad." When he tells a resident about his patient, he furrows his brow, shakes his head and says, "Wherever this man and his wife live, don't drink the water."

Back at the nursing station, somebody has thrown a handful of candy on the counter. Several people eye it. One says, "Give it to a resident, they'll eat it." A sign on the wall reads "Anti Stress Kit." It features a large circle with these words inside: "Bang Head Here."

"It's mandatory to have a good sense of humor, and to maintain that," Doctor Walker says. "It's a way to deal with events that are shocking or stressful — so that you can focus back on the person and not be overwhelmed by the emotional side."

Most medical schools do what they can to provide students with knowledge of coping techniques, Doctor Walker says. But it's more important for physicians to be aware of their own per-

sonalities and coping styles before choosing a specialty.

"Just like people have different tolerance levels for pain, people have different tolerance levels for stress," he says. "It's something that has to be considered when you pick your specialty."

"Medical schools can teach techniques, but will people use it, apply it? Before you pick a specialty you've got to know what you're getting into — and if it's too stressful you should choose something else."

"I like what I do, but I take time for myself," he adds. "You learn what to do to take care of yourself."

Doctor Walker's natural sociability has been an asset in his position. He enjoys the camaraderie of the emergency room.

"You need to be personable because you're going to meet everybody under the sun — from an executive CEO to an indigent found on the edge of a curb. Personality is important, because you have only a brief time to get to know the person, find out what's wrong and make decisions."

"The emergency room is one of my social groups," he adds. "It's like a little family. Everybody shares the same weird hours, so you do things together — like going out to breakfast after work."

The emergency room is a microcosm of humanity. Throughout this one evening, Doctor Walker deals with problems related to old age, poverty, alcoholism, drug addiction, teenage pregnancy, venereal disease and crime. Among his patients is a girl who suffers from asthma. She smokes. Another young woman has come in so drunk she slumps unconscious in a wheel chair. A man has fallen down a flight of stairs, punching a hole in the drywall at the bottom with his head. Police say none of his friends would accompany him to the hospital because they are celebrating the birth of kittens. Still another patient, reeking of alcohol, claims he hasn't had a drink since yesterday, and yesterday he only had one. His alcohol level comes back .35.

"It's mandatory to have a good sense of humor, and to maintain that. It's a way to deal with events that are shocking or stressful..."

How does Doctor Walker react to these patients, the ones that are ill because they have drunk, smoked or eaten too much? The ones who lie? How does it affect the way he treats them medically, or personally? Some people might say it's their own fault.

"They're still hurt," Doctor Walker says. "If you had that kind of attitude in the emergency department you wouldn't last very long. We see every kind of patient here. We see patients nobody else sees.

"You see a lot of the drunks over and over again. They're the incorrigible ones. They come in, and you get them in for treatment. They dry out for awhile, but then they're back.

"Once in a while they surprise you though," he adds, "and they'll come in and tell you they've been sober for a year. They remember you, and they're really grateful that you helped them."

At 10:45 p.m., another call goes out for the Trauma Activation Team. A man has jumped off a 25-foot overpass, landing on his face. While they wait for the ambulance to arrive, Doctor Walker and several residents ready the Trauma Room, preparing IV's and monitors, checking supplies. Surgical residents arrive. Because it's a possible death, a chaplain is called.

There are 10 medical personnel in the room when police arrive with the patient. He's moved from the gurney to the table. Six people start working on him, cutting off his clothes, intubating him, talking to him. He is conscious. Doctor Walker asks, "Did you try to kill yourself, Ruben?" He says, "No." The patient is very drunk. Perhaps he fell off the overpass. His face is covered with blood. Someone finds a six-inch crucifix in the patient's pocket.

"I don't know if there's been a 'worst'," says Doctor Walker, when asked for the worst problem he's ever faced as an emergency physician, "but I do know this: Life doesn't imitate art; art imitates life. For every story you might make up about the emergency room, I can tell you two real ones that are weirder."

At 11:45 p.m., Doctor Walker looks at the clock. He reaches his hands back to rub his neck. "It's been

a decent day," he says. "Can't complain." In about 15 minutes he will go home to his house and his yellow lab, Bear. He might fire up his computer. It will take him until about 1:00 a.m. or 2:00 a.m. to wind down. Then he'll get some sleep. ■

Karen Bouffard is a Williamston, Mich.-based freelance writer.



Doctor Walker at home with "Bear."

Tomorrow's Leaders

Young physicians critical to future of MSMS

Involvement of today's young physicians is critical to the future of MSMS, according to MSMS Young Physicians Section leaders.

"It's essential for young physicians to be involved, because someday they will be in charge," says Greg Walker, MD, who was elected chair of the MSMS Young Physicians Section in March. "With regard to health care, the wheels are going to roll no matter what. There has to be a group among us that is compelled to make sure they roll the right way. It's essential that physicians participate in the process of change."

Seventy percent of MSMS members who joined last year were young physicians (and medical students)," says Carol van der Harst, MD, immediate past chair of the MSMS Young Physicians Section and a Bay City psychiatrist. "Yet, we still do not have the level of involvement by young physicians needed to impact today's policies or to develop leadership for the future."

"Young physicians new in practice need others who have joined organized medicine to offer them a hand into that system, where issues that arise can be taken to a higher level and be put into political interventions. Participation in the Young Physicians Section provides this."

According to Tama D. Abel, MD, a past chair of both the AMA and MSMS Young Physicians Sections, "Traditionally, the leadership has been an 'Old Boys Club' where the woman, IMG or young physician has found it difficult or even impossible to participate. The feeling on the part of young physicians has been, 'If you can't participate, why join?'"

"In fact, we have seen quite a diversity growing in our leadership," adds Doctor Abel, who is the assistant medical director of Maple McAuley Urgent Care in Ann Arbor. "The last 10 years I've seen more women involved, and more young people in leadership spots. I've seen those demographics change."

"As the membership has diversified, the lead-

ership needs to also. If nobody participates, there isn't going to be anybody to lead — to fill those shoes."

Doctor van der Harst says

young physicians have both much to give and much to receive through participation in MSMS.

"It is often the youngest physicians that feel most strongly the impact of health care policies on medical care, because they are the most frustrated. Older physicians who are experiencing a limitation for the third or fourth time are more calloused to the situation, so they don't react as strongly."

"Without organized medicine, the observations and discoveries that young physicians make would be unlikely to make it into any kind of format that politicians would be likely to understand or pay attention to."

According to Doctor van der Harst, another benefit of participation in the Young Physicians Section is interaction with peers. "Joining the YPS has provided the easiest access for me to other young physicians who are at a similar stage of practice development. It's given me an opportunity to meet others all over the state and in other states by attending state and national meetings."

For more information on the MSMS Young Physicians Section, contact Deborah Zannoth at MSMS. Phone: (517) 336-5763. E-mail: dzannoth@msms.org. ■ —K.B.

"It's essential for young physicians to be involved, because someday they will be in charge."

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Demographics

Young physicians opt for specialties, employed positions, MSMS research shows

By Julie L. Lester

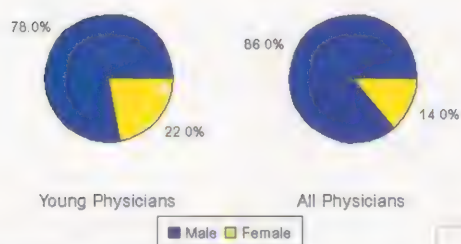
Changes in the health care market are influencing the choices that young physicians make, as demonstrated in the 1994 MSMS Survey on Practice Characteristics. This member survey included responses from 401 young physicians, defined as those age 40 or younger or physicians who have been in practice less than five years.

The increasing presence of female physicians was reflected among young physician members responding to the survey. Twenty-two percent of young physicians were female, as compared to 14 percent of all physicians. Like their older counterparts, young physicians were more likely to be specialists. Young physicians were more likely to have graduated from Michigan medical schools (58 percent versus 50 percent for all physicians).

They were also much less likely to be in solo practice (24 percent versus 40 percent for all physicians). They chose group practice settings more frequently (44 percent versus 30 percent), and were accepting employed positions in equivalent numbers (32 percent versus 30 percent). The type of practice influenced how their liability coverage is purchased as well. Although the presence of managed care continues to grow for all physicians in Michigan, young physicians were slightly more likely to have contracts with managed care plans. ■

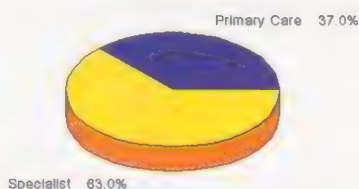
The author is chief of health care research for MSMS.

Gender Distribution



SOURCE: MSMS Survey on Practice Characteristics, 1994

Young Physicians: Focus of Practice



SOURCE: MSMS Survey on Practice Characteristics, 1994

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Medicare:



Number 5

Planning for Retirement...Despite Medicare's Future

By Earl G. Moehn, MD, Chair
MSMS Group Insurance Trust



All the controversy swirling around Medicare this year pales in comparison with what will happen in 15 years--when baby boomers begin reaching age 65--if meaningful changes to the program are not implemented in the near future. In 2011, what will the program offer? To whom? At what price?

One thing is certain: In 2011, Medicare will not be the same as it is today. Either changes will be made now and phased in over the next 15 years, or continued political impasse will bankrupt the Medicare Trust Fund by 2002, forcing the program to be dissolved or radically restructured. Given the program's popularity, implementing gradual change is the most likely scenario. Meanwhile, despite the uncertainty, everyone--including physicians--must plan for retirement. This article highlights possible long-term changes to Medicare and suggests practical approaches people can take to prepare for their health care needs in retirement.

What Could the Future Bring?

Higher Beneficiary Premiums and Copayments. In 1993, the average per capita out-of-pocket personal health care expense to Medicare recipients was nearly \$3,000, reflecting an annual growth rate of 7.3 percent since 1990. For simplicity's sake, assume that this growth rate will remain constant until 2011, which means that the \$3,000 in 1993 will become \$10,664 in 2011. The actual figure is likely to be higher, however, because beneficiary premiums and/or co-payments probably will go up, especially for retirees with higher-than-average retirement income.

Reduced Reimbursement to Physician and Hospitals. Cuts in Medicare payments to physicians and hospitals are certain to raise costs indirectly for retirees who elect Medigap coverage. When providers "cost-shift," i.e., charge private payers more to make up for under-reimbursement by Medicare, the private payers, such as Medigap insurers, charge higher premiums.

Changes in Coverage. An alternative to reforming Medicare strictly through financial means is to reform it by altering what the program covers. The most obvious way to reduce costs is to reduce coverage, and this could be accomplished by not paying for certain types of benefits or by raising the eligibility age. Medigap plans probably would fill the gaps by expanding their coverage options--and their costs, which for low-and middle-income seniors could put Medigap policies financially out of reach.

Another scenario, although not necessarily cost-neutral, is to alter the current Medicare coverage structure. One example is to combine Medicare parts A and B into one policy. Another is to include in Medicare coverage the supplemental coverage provided now by Medigap policies. Since administrative costs are markedly lower for Medicare than in the private sector (only two percent of Medicare spending is for administration, compared to 5.5 percent in the large-group market and 25 percent in the small-group market), combining the programs could reduce administrative costs.

Conversion to a Voucher Program. Under this scenario, Medicare enrollees would choose from a variety of health insurance options, such as enrolling in a managed care plan, opening a medical savings account (a high-deductible policy with discretionary money to spend on services or personal items), or opting for the current fee-for-service arrangement. Although competition among the various insurance options could drive coverage costs down somewhat, if Medicare's current

(continued on following page)

Critical Analysis



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generous coverage continues, expect prices for most policies to be high. Some estimates show that currently, for people aged 65-74, private-sector coverage comparable to Medicare parts A and B would mean annual premiums of \$6,400 to \$8,500. Most likely, the federal government would not be able to sustain such rates, and individuals would be responsible for significant portions of the costs.

Expanded Enrollment in Managed-Care Plans. Recently available data reveal that as of June 1995, nearly 9 percent, or 3.2 million Medicare beneficiaries, were enrolled in 250 private managed-care programs, most of which are health maintenance organizations. It is questionable whether managed care can save money for Medicare, because people who enroll in managed care tend to be more healthy than those in fee-for-service arrangements; this means that if they were in the fee-for-service sector, they wouldn't cost as much as others. Thus, the rate at which Medicare beneficiaries may be required to enroll in managed-care plans could depend on whether managed-care payment strategies can be developed that will save the program money.

Comprehensive Health Care Reform. This is not likely, and no one should plan for retirement expecting such a scenario.

What Should You Do?

Predicting the specific changes that will be made to the Medicare program is impossible, but it may be safest to assume that some of each of the options above (except for comprehensive reform) will be incorporated into the program. Despite the uncertainty, there are certain practical steps that people can take to prepare for retirement.

- Know your expected retirement income from Social Security and retirement accounts. For information about your future Social Security benefits, every few years call the Social Security Administration at 1-800-772-1213 and request a personal earnings and benefit estimate statement.

- Think about how long you want to work. While some people fully retire before they reach age 65, others prefer to combine work and retirement and keep their employer-sponsored health plan longer. When you are considering the age at which you expect to fully retire, keep in mind that the Medicare eligibility age probably eventually will rise.

- Save and invest a portion of your income. The younger you begin saving, the more your money will work for you. For some physicians, being able to save in the face of student loan repayments may mean practicing for a few years in an underserved area in order to receive loan-repayment assistance. The latest Physician Payment Review Commission report says that speculating on future Medicare and private-payer rates is difficult, which means that it is also difficult for physicians to estimate accurately their future earning potential. All the more reason to set short-and long-term savings goals and review them periodically.

- Consult with a financial or estate planner for personalized assistance.

- Estimate your potential health care needs during retirement, taking into consideration that people are living longer and requiring more health care services. If you or your family has a history of chronic illness, you will need to set aside more than the minimum.

- Whatever your age, consider purchasing long-term care insurance. Medicare does not cover long-term nursing home care, and its cost is one of the most catastrophic expenses that families face.

- Learn now about your options for purchasing health insurance when you retire. Consider making arrangements with your employer (or the potential purchaser of your practice) for you to have continued coverage when you retire.

- Stay healthy! It goes without saying that the more that people take care of themselves, the less likely they are to need services for preventable health problems.

- Stay informed about Medicare changes.

- Get involved in the political debate about Medicare changes. Work with groups that offer solutions that benefit the elderly and disabled of today and yourself in the future.

Conclusion

No one knows for certain what Medicare will look like in the future. Any changes to the program made now inevitably will be reevaluated and altered as time goes on and needs change. The most practical strategy, especially for baby boomers, may be to hope for the most advantageous program but plan for the least.

This is the fifth in a series of monthly articles that examine aspects of Medicare.

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MMGMA aligns with MSMS

Both sign first-of-a-kind collaboration agreement

By Marsha Bassett

The Michigan Medical Group Managers Association (MMGMA) has signed a collaboration agreement with the Michigan State Medical Society (MSMS), making it the first state chapter of the Medical Group Managers Association (MGMA) to sign such an agreement with its state medical society.

The agreement, designed to formalize the relationship between the two organizations, is modeled after the affiliation agreement between the American Medical Association and MGMA. The agreement covers five areas: advocacy, education, member benefits, administrative assistance and committee participation.

Advocacy

As part of the agreement, MMGMA members may now participate in the MSMS Physician Legislative Network -- a statewide system which issues alerts and updates to keep participants abreast of current legislative issues. It also encourages participants to use that information to develop relationships with lawmakers.

The agreement also directs MMGMA and MSMS legislative representatives to meet regularly to discuss issues and devise plans of mutual benefit to the organizations' members. In addition, MMGMA and MSMS will collaborate on providing legislative speakers and speaker information for conferences. They will also collaborate on sending teams of members to the Annual Joint MGMA/AMA Legislative Conference.

Education

Educating members is a top priority and strength for both organizations. As part of the agreement, members of either organization will be afforded the opportunity to participate in the other organization's educational offerings, and at a discount.

In addition, the groups will work together to coordinate the times and subjects of their conferences to avoid duplication and conflict. They will also share speaker information and provide speakers for conferences when appropriate.

Member benefits

Since both groups strive to offer benefits of value to their members, the agreement offers ways to enhance membership in both organizations.

MSMS offers its products and service discounts to MMGMA members, including discounts on cellular telephones, insurance and subscription services. In addition, MSMS has opened its discounted Internet connection (via MSMSNET) to MMGMA members. To enhance Internet access for both member groups, MSMS is helping MMGMA develop its own Internet homepage.

The agreement also supports the groups working together to enhance the MMGMA Placement Service, which provides information about job openings to MMGMA members.

Administrative assistance

For years, MSMS has provided quality administrative services to MMGMA. The agreement will serve to enhance our relationship, especially as it concerns confidentiality and independence.

Committee participation

MSMS has a sophisticated and influential array of committees on many subjects of interest to MMGMA. Though MMGMA has served on many of these committees, the agreement formalizes this arrangement, thus allowing MMGMA members to sit on most MSMS committees. Committees of particular interest include rural health care, Medicaid, federal and state legislation, risk management, technology,

"Though the agreement has been in effect for only a few months, it already has created a win-win situation for both organizations."

and third party payors.

A win-win situation

The agreement invites members of each organization to have a representative attend at least one of the other group's board meetings each year. It also establishes regular meetings of the organizations' leadership to ensure that the relationship grows and evolves appropriately in response to changing markets.

Though the agreement has been in effect for only a few months, it already has created a win-win situation for both organizations. The relationship between the two organizations is positive and strong. It is the belief of both MMGMA and MSMS that members will enjoy the benefits of this new relationship.

If you are interested in receiving a copy of the agreement, or would like to learn more about the process, you may contact me at (616) 381-7380 Ext. 230.

Marsha Bassett is immediate past president of the Michigan Medical Group Managers Association.



Leaders of the Michigan Medical Group Managers Association (MMGMA), Michigan State Medical Society (MSMS) and the Medical Group Managers Association (MGMA) gathered at MSMS headquarters late last year to witness the signing of the collaboration agreement between MMGMA and MSMS. They were (l to r, back row): Kevin A. Kelly, MSMS Managing Director; James R. Tarrant, General Manager, MSMS Subsidiary Operations; Eric Thompson, MMGMA President-Elect; Gary Paavola, MMGMA President; and William E. Madigan, MSMS Executive Director. Front row (l to r): Cynthia Bodewes, Chair, MMGMA Legislative Committee; Fritz Wentzel, MGMA Executive Director; and Marsha Bassett, MMGMA Immediate Past President.

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Amod Tootla, MD

The Virtual Physician

By Ralph D. Ward

The information superhighway is proving its value for one Michigan physician by helping to spread the word on a new surgical procedure.



Amod Tootla, MD, has added a new personal web site as a promotion tool for his revolutionary laparoscopic colectomy technique. Doctor

Tootla, a Pontiac area colorectal surgeon, has gained national attention for his pinpoint colectomy technique. He received a recent writeup in *The Oakland Press*, and will soon be featured on the ABC TV program "20/20."

The use of laparoscopic techniques for a colectomy results in "a patient cost about half of regular techniques, and the patient is back to work in a week or two," says Doctor Tootla. With typical patient costs running to \$15,000 by regular methods, the savings are substantial.

The intrusiveness of Doctor Tootla's laparoscopic technique is far less, and healing much faster. "I did a patient on Wednesday, he was home on Friday, and Sunday he was out shopping at the Oakland Mall," recalls Doctor Tootla.

So what's the next logical step to promoting this new technique? Go on-line. A web page explaining the laparoscopic colectomy method went online on April 13, and is already proving to be popular as an informative tool and medium for recruiting residents.

By logging on to <http://www.eaglequest.com/~atootla>, browsers can "see that this service is available, that we can train any surgeon, and will learn how to set up a program in their hospital."



The author is a Riverdale, Mich.-based freelance writer.



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In order for a Physician to protect his/her patient base from eroding, they are going to have to be able to answer questions about their practice. Information about a practice is paramount to its survival. A successful medical practice is going to have to monitor costs, track revenues, monitor reporting methods, and create policies and procedures that lower administrative hassles. The tracking of patient information, the tracking and follow-up of incorrect carrier reimbursements, establishing audit trails for coding, creating policies and procedures to lower administrative hassles all will come from a good information system and knowing what to do with that information.

"*What does it mean when my adjustments are too High?*" Are they considering the multiple factors that could lead to this; invalid diagnosis and procedure coding, insurance claims being adjusted too early. "*What does it mean that my collection percentage is too low?*" Have they considered looking at their adjudication process, is their data gathering and insurance tracking being done properly?

We at Medical Management Systems of Michigan, Inc., feel in order to assist our Physicians we need to be able to provide them with information that will allow them to make accurate and well informed decisions about their future and the future of their practice. We are able to assist the physician in protecting their income, protecting their practice as well as allowing them to be part of a surviving health care delivery system.

By Jeanne P. Rutledge

The following is a half-day continuing medical education program sponsored by Blue Cross Blue Shield of Michigan and presented by the Medical Staff of Oakwood Hospital and Medical Center – Dearborn.



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Saturday, June 1, 1996



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Purpose and Intended Audience

The purpose of this seminar is to address current problems and patient care approaches in primary care medical practice. Selected problem diagnoses will be clarified in light of the most recent knowledge and practice. Emphasis will be placed on alternative but not necessarily unconventional approaches to caring for the whole patient in an effort to ensure compliance and enhance the probability of success of all therapeutic interventions.

Objectives of the Symposium

At the conclusion of the program, the participants should be able to:

- Review selected diagnoses/conditions which may be challenging to the primary care physician.
- Discuss the essentials of the diagnosis of these conditions.
- Outline the appropriate initial therapy as indicated by the severity of the findings.
- Recognize the role of alternative therapeutic modalities in the management of common problems.
- Learn to use a collaborative and negotiated approach to ensuring compliance with long term recommendations.

The views and opinions expressed by the speakers/panelists do not necessarily reflect those of BCBSM or current BCBSM medical policy.

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CME Program Director

John J. Siller, M.D.

Associate Medical Director – Education
Blue Cross Blue Shield of Michigan

Program Director and Moderator

Nicholas J. Lekas, M.D., F.A.C.P.

Director, Internal Medicine Residency
Clinical Associate Professor
Department of Internal Medicine
Wayne State University

Program Agenda

- 7:15 AM Continental Breakfast**
- 8:00 AM Welcome and Introduction**
John J. Siller, M.D.
Moderator
Nicholas J. Lekas, M.D., F.A.C.P.
- 8:10 AM Depression, Recognition and Management**
Steven Aronson, M.D.
- 8:50 AM Management of Chest Pain in the Primary Care Setting**
Arthur Riba, M.D., F.A.C.C.
- 9:30 AM Sexually Transmitted Diseases, New Concepts**
Stanley Miller, M.D.
- 10:10 AM Break**
- 10:30 AM Alternative Medicine, Current Concepts and Role in Primary Care Practice**
Clinton Lido, M.D.
- 11:15 AM Negotiated Health Care in the Elderly**
Paul Seifert, M.D., F.R.C.P.(C)
- 12:00 PM Open Panel/Discussion**
- 12:30 PM Adjourn**

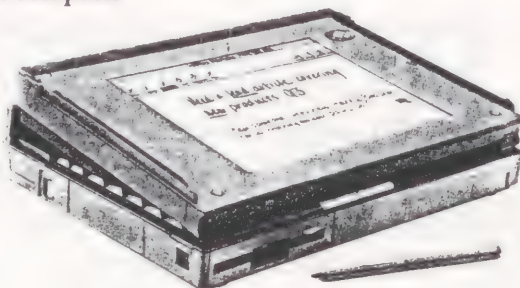
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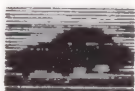
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James K. Haveman, Jr.

Building Michigan's public health care future

When James K. Haveman, Jr., 52, was brought up in Grand Rapids in the 1950s, he was taught by the Christian Reformed Church that it is the responsibility of each person to try and make the world a better place. He also learned from his father, a prominent architect of Michigan schools and churches, how to build dreams into reality. "As an architect, my dad could visualize something, and then turn it into a drawing. I have that ability, but I apply it to health care, instead of to buildings," he says.



His defining characteristic, says Haveman, is "an ability to listen to the hopes and the vision people have, and then move a system toward that objective." That task isn't always easy, he adds. "Large systems have a way of retracting. People want to go back to the old way, but I'll keep moving the process. I'm not afraid of change."

Haveman says it was a "tremendous moment" for him in August 1996 when Governor John Engler asked him to undertake a functional analysis of the 14 Michigan departments that held health-related

responsibilities, and to propose ways to increase efficiency and effectiveness. "I was struck with a sense of the trust that was being placed in me," says Haveman, who was at that time the acting director of the Michigan Department of Public Health, "and of the awesome responsibility that I was about to undertake."

On January 31, 1996, Governor Engler created

by executive order the new Michigan Department of Community Health, of which Haveman was the principal architect. Haveman was named DCH director on April 1. Following months of listening to the frustrations, needs and visions of others, Haveman designed a new department that consolidates the health planning, purchasing, financing, and administrative functions of the former Departments of Public Health, Mental Health and

Medical Services Administration (the state Medicaid program.) According to Haveman, the Michigan Department of Community Health is one cohesive unit, replacing numerous fragments. The new structure will allow for larger economies of scale in purchasing, and for increased opportunities for collaboration. The result, says Haveman, should be "a more seamless way to deliver care."

Haveman attributes much of his administrative ability to his college training and early career experiences. Having started out as a business major at Calvin College in Grand Rapids, Haveman was encouraged by his wife Barbara, to whom he's been married nearly 30 years, to take a class in sociology. He liked it so well that he changed his major, graduating with a degree in social work in 1966. After earning his master's degree in social work from Michigan State University, he joined Project REHAB in Grand Rapids, a substance abuse treatment agency with several programs throughout Michigan, where he was executive director from 1971 to 1978.

"My master's training was very clinical, very treatment focused," he says. "I really welcome that background today. It taught me the dynamics of people. I really enjoy working with groups. Coming from a clinical background, you use those

skills all the time--whether you're dealing with families or with large groups."

Haveman says he got his first administrative experience at Project REHAB. "I had to do it all, because there were only four of us there. Much of what I know today about administration, I learned there."

A major lesson he learned at Project REHAB, he says, is "always start where the recipient is. I believe in keeping the focus on the consumer, and bringing the services to them. I'm not married to existing structures. I'm more than willing to look at change."

After Project REHAB, Haveman served as executive director of Bethany Christian Services from 1985 to 1990. It was at Bethany, one of the nation's largest international adoption agencies, licensed in 28 states and several foreign countries, that Haveman had an opportunity to develop a more global perspective of health care.

"At Bethany, I traveled all around. I visited hospitals all over Asia and Africa. I've seen what happens to communities where there's no health care," he says. "They fall apart."

On December 26, 1990, Haveman was named director of the Michigan Department of Mental Health. "I had met John Engler just twice before I got the job," he recalls. "He called and said, 'I need you in three days'—and in three days I left Grand Rapids and walked into this new world of Lansing." Haveman was named acting director of the Michigan Department of Public Health in July 1995.

Haveman's family home is in Grand Rapids. He keeps a Lansing apartment where he stays Monday through Friday, and spends weekends at home with his wife, Barbara. May through August, the couple spend most weekends at their cottage on Lake Michigan where they receive frequent visits from their daughter Shane, 24, a special education teacher in Grand Rapids, and son Daniel, 26, a mechanical engineer, Daniel's wife Sue, and their two grandchildren, Nick, age 2 and Jackson, a newborn.

Haveman's plans for the future include reducing the tremendous amount of paperwork that now wastes valuable health care dollars. "People talk about reducing it," he says. "I'm going to do something about it. People don't go to medical school to learn how to do paper work."

Another goal is to emphasize wellness and prevention programs. He had the dual pleasure of presenting Michigan's new comprehensive plan to address Michigan's poor immunizations record at a (January) press conference at which he introduced his grandson, Nick.

"What we need here is an integrated approach to health. We have a long way to go to upgrade the health of Michigan citizens. It's time to put the emphasis on wellness."

Haveman notes that he relies heavily on input from others to achieve his goals. "I'm not a 'we/they' person, I'm an 'us' person," he says. "I'm a real believer in a whole lot of partners working together." ■ —K.B.

Comment Line

If you would like to comment on an article in *Michigan Medicine*, or any other aspect of the magazine, please do not hesitate to contact Betty McNerney, Editor of Publications, at (517) 336-5749, or by FAX at (517) 337-2490, or E-mail at bmcnerney@msms.org

**Our goal is to continuously improve
Michigan Medicine. We welcome
your participation in that process.**

Newsmakers

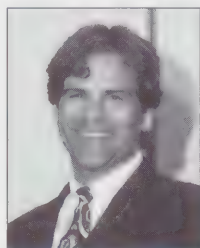
Marigowda Nagaraju, MD, a Flint gastroenterologist and founder



of the Genesee County Free Medical Clinic, is the recipient of the 1996 Clement A. Alfred Humanitarian

Award. The award, which was established in 1991 by members of Alfred's family, recognizes local health care professionals for outstanding dedication and for concern about the community. Doctor Nagaraju was chosen for the award for what has been described as his "tireless effort" to found the Genesee County Free Medical Clinic.

Kurt O. Doggwiler, MD, PhD, a radiology resident at Wayne State University/DMC Affiliated Hospitals, is one of 50 outstanding young medical professionals who were honored by the American Medical Association at its annual National Leadership Conference held in March. The AMA/Glaxo Wellcome Achievement Award is presented to 25 medical students and 25 residents in recognition of their exceptional leadership abilities in medicine or

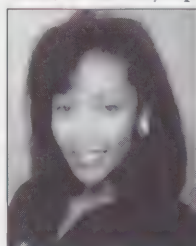


achievements in non-clinical community activities.

Three Michigan physicians are newly-appointed members of the Michigan Board of Medicine. They are: **Linda S. Hotchkiss, MD**, of Wayne County; **Kenneth J. McNamee, MD**, of Monroe County; and **Appa Rao Mukkamala, MD**, of Genesee County. Two Michigan physicians have been reappointed to the Board. They are: **Douglas A. Mack, MD**, of Kent County; and **Harold J. Sauer, MD**, of Ingham County.

D. Eugene Thompson, MD, has been re-elected secretary of the board of directors of the American Academy of Orthopaedic Surgeons. Doctor Thompson is a practicing orthopaedic surgeon with William Beaumont Hospital-Royal Oak, and past president of the Michigan Orthopaedic Society.

Stella M. Bulengo-Ransby, MD, recently opened Dermatology



& Skin Pathology Consultants, PC, in the Medical Village, Beverly Hills, offering dermatology and dermatopathology services. She did her undergraduate, medical school and residency at the University of Michigan in Ann Arbor. She is on

staff at William Beaumont Hospital in Royal Oak and Troy.

Edward A. Krull, MD, chair of the Department of Dermatology at Henry Ford Hospital, was recently awarded the Gold Medal of the American Academy of Dermatology. The highest honor given by the Academy, Doctor Krull received the Gold Medal award in recognition of his development of surgery as an important part of dermatology and for establishing dermatology as both a medical and surgical specialty. He was also cited for his many contributions to the study of nail diseases and disorders of the mouth and mucous membranes.

John M. Kisala, MD, FACS, East Lansing, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Lawrence Hospital & Healthcare Services. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Doctor Kisala is among a national network of over 2,000 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities. ■

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Pablo H. Abrego, MD, Allegan

Jalal U. Akbar, MD, Deckerville

Guilbert O. Arcay, MD, Saginaw

Stephen M. Aronson, MD, Ann Arbor

Ramesh B. Avula, MD, Lansing

Ronda Barak-Norris, MD, West Bloomfield

Orlando I. Benedict, MD, Grand Blanc

Karumarchi Bhaskaramma, MD, Kingsford

Kurt M. Carter, MD, Lansing

Doris D. Cataquiz, MD, Saginaw

Ramiro Daza, MD, East Lansing

A. Luisa DiLorenzo, MD, Troy

Myriam A. Edwards, MD, Grand Blanc

Michael F. Engel, DO, Traverse City

Mini Bansal Goddard, MD, Monroe

John R. Harding, MD, Warren

Kamal S. I. Hasan, MD, Tecumseh

Joseph W. Hosner, MD, Kalamazoo

Alicia F. Imperial, MD, Flint

James B. Johnson, MD, Holland

Othman Kadry, MD, Pontiac

Quresh T. Khairullah, MD, Detroit

Phyllis J. Lashley-Alder, MD, Battle Creek

Miles P. Light, MD, Saginaw

Douglas L. McKay, MD, Plymouth

Andrea B. Miller, Montreal

Gregory L. Miller, MD, Grand Rapids

Ronald C. Miller, MD, Lansing

Wilfredo Z. Momblanco, MD, Garden City

Elie Mulhem, MD, Houghton Lake

An G. Nguyen, MD, Grand Rapids

Allan Olson, DO, Marquette

Thomas J. Ruane, MD, East Lansing

Randolph B. Russo, MD, Grand Rapids

Howard M. Sandler, MD, Ann Arbor

Young Seo, MD, Bloomfield Hills

Krishna J. Shah, MD, Burton

Steven A. Shanbom, MD, Southfield

Andrew A. Shinar, MD, St. Clair Shores

Steven V. Thomas, MD, Traverse City

Raymund M. Untalan, MD, Crystal Falls

Chandrasekar Venugopal, MD, Detroit

Roderick D. Walker, MD, Detroit

James Wiaduck, MD, Grand Haven

Marcel E. Zughaib, MD, Southfield



Deaths

Richard M. Kommel, MD, a retired otolaryngologist, died March 7, 1996. He was 68. A 1955 graduate of the University of Michigan Medical School, Doctor Kommel was a past president of the Macomb County Medical Society and has served both as chief of staff and chief of surgery at St. Joseph's Hospital in Clinton Township.

John R. Pracher, MD, a retired radiologist, died January 4, 1996, at the age of 77. A 1943 graduate of the Louisiana State University School of Medicine, Doctor Pracher had been affiliated with Oakwood Hospital. He was a member of the Wayne County Medical Society and MSMS.

Sidney E. Smith, MD, a Genesee County general surgeon, died March 12, 1996. He was 70. A 1954 graduate of Wayne State University School of Medicine, Doctor Smith had been affiliated with Hurley Hospital, Flint. ■

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: F.E. Audretsch, MD, 355 Lincoln Rd., Grosse Pointe, MI 48230

Action, Date Taken: License Suspended - 6 mo. & 1 day, 04-05-96

Reason: Failure to Meet Continuing Education Requirements

Name: Bruce E. Baker, MD, P.O. Box 7141, Fredericksburg, VA 22404

Action, Date Taken: License Revoked, 04-05-96

Reason: Mental/Physical Inability to Practice

Name: Harjit S. Bharmota, MD, 317 S. Main St., P.O. Box 27, Marion, OH 43301

Action, Date Taken: License Revoked, Fine - \$1,000.00, 04-05-96

Reason: Drug Related

Name: John T. Boaz, MD Caro Regional Center, Lock Box A, Caro, MI 48723

Action, Date Taken: Probation - 3 yrs., 03-07-96

Reason: Sister State Disciplinary Action

Name: Jimmy W. Brandon, DO, 3413 Hammerberg Road, Flint, MI 48507

Action, Date Taken: License Summarily Suspended, 03-21-96

Reason: Criminal Conviction-Drug Related

Name: Howard L. Burley, MD 3508 Saxton Mist Court, Nashville, MI 37217

Action, Date Taken: Reclassified w/Unlimited License, 02-06-96

Reason: None Given

Name: Maria del Carmen Solo, DO, 680 West Columbia, Battle Creek, MI 49015

Action, Date Taken: Reinstatement Denied, 03-04-96

Reason: None Given

Name: Scott D. Cobel, MD, 10299 Orchard Lane, Lakeview, MI 48850

Action, Date Taken: Reinstated w/ Limited License - minimum 2 yrs., Probation - 2 yrs., 03-07-96

Reason: None Given

Name: Ramon R. Duarte, MD, 449 Adams, Rochester Hills, MI 48309

Action, Date Taken: Reinstated w/Limited License, Probation concurrent w/limited license, 03-07-96

Reason: None Given

Name: Timothy B. Elliott, DO, Baldwin Family Health Care, 4967 N. Michigan Avenue, Baldwin, MI 49304

Action, Date Taken: License Summarily Suspended, 03-12-96

Reason: Substance Abuse

Name: Abdelkader H. Fares, MD, P.O. Box 433, Dearborn Heights, MI 48127

Action, Date Taken: Reconsideration of Final Order dated 11-14-95, License Revoked, Fine - \$5,000.00, 04-05-96

Reason: Criminal Conviction

Name: John W. Finn, MD, Hospice of SE Michigan, 16250 Northland Dr., Southfield, MI 48075

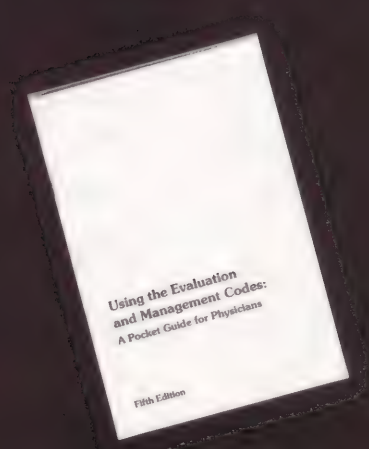
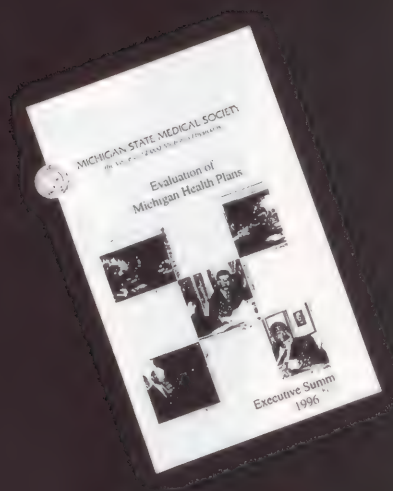
Action, Date Taken: Reclassified w/Unlimited License, 03-06-96

Reason: None Given

(continued on page 53)



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—Regina M. Benjamin, MD, AMA Board of Trustees

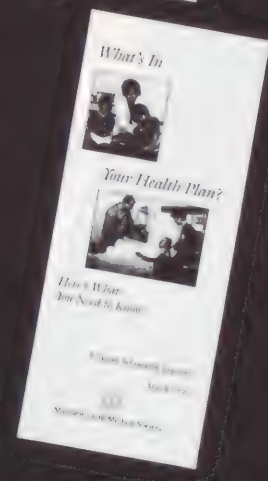
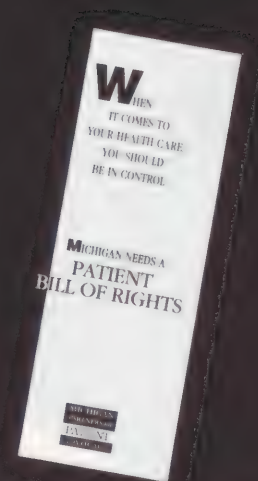
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_____	Your Health Plan Brochure (First 50 free, \$25 per 100)	\$ _____
Immunizations Materials		
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Continued from page 50

Name: Joann M. Gates, MD, 1740 Woodward Ave.,
Unite 38, Bloomfield Hills, MI 48304

Action, Date Taken: Reinstatement Denied, 02-16-96

Reason: None Given

Name: Claire E. Hendershott, DO, 900 N. Main St.,
P.O. Box 1395, Rochester, MI 48308

Action, Date Taken: Summary Suspension Dissolved -
Deceased, 02-01-96

Reason: Deceased

Name: Robert L. Kamp, MD, 137 Benzie Blvd., Beulah,
MI 49617

Action, Date Taken: Summary Suspension Dissolved -
Deceased, 02-14-96

Reason: Deceased

Name: Eli J. Khalili, MD, 100 Michigan Street NE,
Grand Rapids, MI 49503

Action, Date Taken: License Revoked, Fine -
\$1,000.00, 04-08-96

Reason: Criminal Conviction-Drug Related

Name: George C. Lakatos, MD, 10501 76 Street, South
Haven, MI 49090

Action, Date Taken: Probation - 2 yrs., Fine - \$5,000.00,
03-07-96

Reason: Probation Violation

Name: James W. Ledrick, MD, 7505 Aspenwood, SE,
Grand Rapids, MI 49546

Action, Date Taken: Suspended - 6 mos., Limited Li-
cense - min. of 2 yrs., Probation - 2 yrs., 03-13-96

Reason: Negligence/Incompetence

Name: John R. LeFevre, DO, 1782 Sessions Walk,
Hoffman Estates, IL 60195

Action, Date Taken: License Suspended - 1 yr., 02-01-
96

Reason: Mental/Physical Inability to Practice

Name: Mukhtar A. Malik, MD, 808 Euclid Avenue,
Bay City, MI 48706

Action, Date Taken: License Summarily Suspended,
02-18-96

Reason: Criminal Conviction

Name: Ishfaq A. Pendi, MD, a/k/a Ish Haveliwala, a/k/
a Ish Havel, 925 South Dylan Way, Anaheim Hills, CA
92808

Action, Date Taken: Reprimand, Fine - \$1,000.00, 03-
07-96

Reason: Criminal Conviction - Insurance Fraud

Name: W. Gene Schroeder, MD, 2063 Thumb Butte
Road, Prescott, AZ 86303

Action, Date Taken: Reprimand, Fine - \$500.00, 04-
12-96

Reason: Failure to Report Sister State Disciplinary
Action

Name: Veera Sripinyo, MD, 28111 Hoover Rd., #3-A,
Warren, MI 48093

Action, Date Taken: License Revoked, Fine -
\$100,000.00, 04-05-96

Reason: Drug Related

Name: Steven G. Tarangle, MD, 9082 Maplewood, P.O.
Box 159, Berrien Springs, MI 49103

Action, Date Taken: License Suspended, Limited Li-
cense, Probation - 1 yr., Fine - \$1,000.00, 03-01-96

Reason: Drug Related

Name: Clark E. Taylor, DO, 2310 M-119, Condo #20,
Petoskey, MI 49770

Action, Date Taken: License Summarily Suspended,
03-14-96

Reason: Mental/Physical Inability to Practice ■

EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

May

14, Bar-Levav Education Association Ongoing Seminar Series "The 'Alley-Cat' Syndrome: Finding the Suffering Patient Underneath." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

21, Bar-Levav Education Association Ongoing Seminar Series "The 'Alley-Cat' Syndrome: Finding the Suffering Patient Underneath." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

28, Bar-Levav Education Association Ongoing Seminar Series "Providing a Holding Environment for the New Patient." **Sponsor:** Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

June

4, Bar-Levav Education Association Ongoing Seminar Series "Providing a Holding Environment for the New Patient." **Spon-**

sor: Bar-Levav Educational Association. **Contact:** Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075 (810) 353-5333. **Approved for:** 4 hours Category I Credit.

25-29, Internal Medicine 1996 - Advances and Controversies. **Location:** Dublin, Ireland. **Sponsor:** Mayo Clinic and the Department of Medicine, Royal College of Surgeons in Ireland Medical School. **Contact:** Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905 (800) 323-2688.

July

14-16, 10th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. **Location:** The Grand Hotel, Mackinac Island, MI. **Sponsors:** The University of Michigan Medical School, Department of Radiology. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 15 credit hours in Category I of the Physician's Recognition Award of the AMA to be announced.

18-21, Gastroenterology for the Gastrointestinal Consultant. **Location:** Shanty Creek Resort, Bellaire, MI. **Sponsors:** The Uni-

versity of Michigan Medical School, Division of Gastroenterology, Department of Internal Medicine. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12 credit hours in Category I of the Physicians Recognition Award of the AMA.

29-August 2, Dynamic Psychotherapy in the New Era: Possibilities and Problems. **Location:** The Given Biomedical Institute, Aspen, Colorado. **Sponsor:** American Psychiatric Association. **Contact:** Maria Gorrick, (phone) 202-682-6145; (fax) 202-682-6102; (e-mail) MGORRICK@psych.org. ■

ONGOING

Case Studies in Environmental Medicine. **Location:** Your office/home (self-instructional monographs). **Sponsor:** The Agency for Toxic Substances and Disease Registry, Division of Health Education. **Contact:** Michele Borgialli, Michigan Department of Public Health, Division of Health Risk Assessment, P.O. Box 30195, Lansing, MI 48909, (517) 335-9647. **Approved for:** Up to 33 hours of free Category I Credits; 1 per case study.

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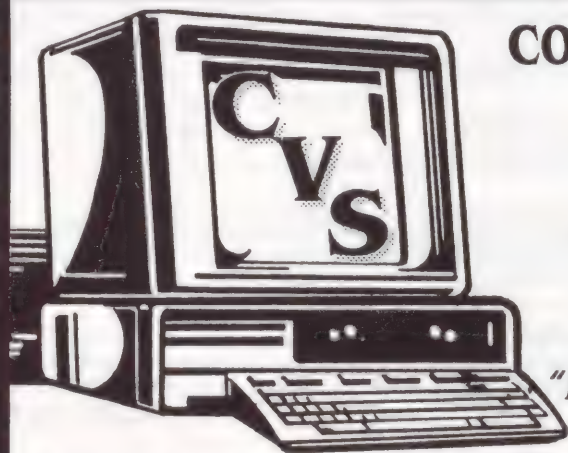
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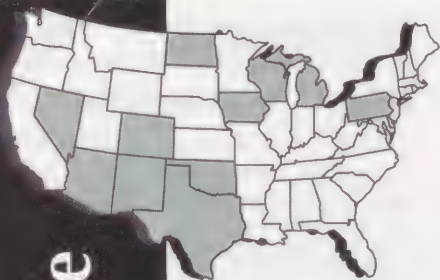
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Internship, Wayne State University, Grace Hospital, Detroit, Michigan
Internal Medicine Residency, Henry Ford Hospital, Detroit, Michigan
Cardiology Fellowship, Henry Ford Hospital, Detroit, Michigan

PROFESSIONAL

Fellow, American College of Cardiology
Fellow, American Heart Association
Clinical Associate Professor of Medicine, Wayne State University, Detroit, Michigan
Consultant, Biomedical Research, General Motors Corporation (Former)
Member, Oakland County Medical Society
Member, Michigan State Medical Society

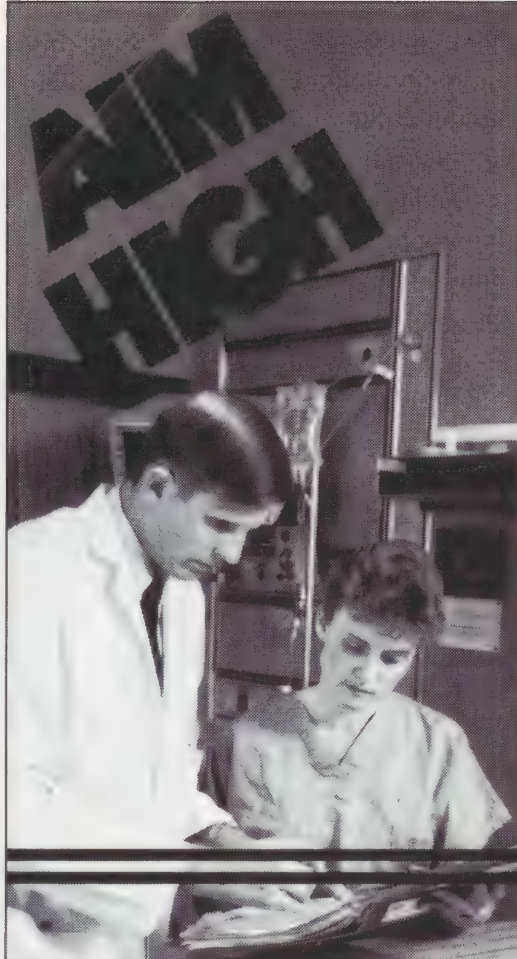
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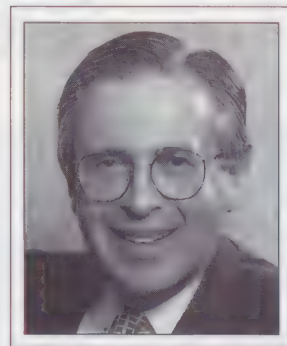
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Lessons from Pogo

If life deals you lemons, make lemonade.

By W. Peter McCabe, MD

For more years than I'd like to remember, we physicians have been calling for fewer specialists and more primary care generalists. We've argued for voluntary restraints on the explosive growth in health care expenditures. We've decried the maldistribution of doctors away from such underserved areas as our inner cities and rural America. And all this has been articulated as if it were due to factors beyond our control. As Mark Twain once said, "Everybody talks about the weather, but nobody does anything about it."

But I wonder whether another wit, the comic strip character Pogo, didn't get a little closer to the mark when he said, "We have met the enemy...and he is us."

Not that we should lacerate ourselves with guilt over all this. But wittingly or unwittingly, we have played a contributory role in the evolution of the dislocations which are causing such upheavals in health care delivery. True, we have not played a major role in the demographic shift of the country toward an older population, but we have kept people healthier during their younger years.

In addition, we physicians have multiplied. When I graduated from medical school in 1965, I was one

of 7,000 doctors newly minted that year. But 1965 was a watershed year: the Vietnam escalation started, and Lyndon Johnson pushed Medicare through Congress and signed it into law. That year was the last of the can-do, know-no-limits bravado era, where anything was possible — win a shooting war half a globe away, and meanwhile fight a medical war at home to conquer heart disease, cancer and stroke.

To achieve these lofty goals, we had to vastly increase physician output quickly to 17,000 per annum. New medical schools were opened all over the country and established ones were enlarged. Those were indeed heady times...for medical school deans and infantry colonels.

Both wars fizzled, one a generation ago. Our medical war took longer to fizzle, but it appears that the manpower chicken has finally come home to roost. We now have a certifiable surplus of physicians. One blue ribbon panel I read of recently suggests closing down some medical schools; another panel says keep most of the schools, but cut their class sizes. Needless to say, there is vigorous opposition to both plans from the predictable sources.

So, we'll probably muddle

through until there's some blood-letting. Meanwhile, we have some bright young people not able to find jobs. I never thought I'd see that.

Again, some of this has been due to forces beyond our control. But in another sense it's the old Pogo theme, an inability to either restrain our own growth during the salad days, or to distribute our specialists in a more sensible pattern. We almost seem to be crying out for someone to save us from ourselves, from that seemingly addictive urge to do more with more personnel.

Unfortunately, that "someone" is here, and I need not elaborate upon who it is. Cost-conscious medicine, giving homage to the great god of the Bottom Line, appears unwilling to tolerate what sometimes seems to be a form of medical featherbedding. If a winnowing out process can be achieved with minimal bloodshed, we may find this to have been a very constructive process. I personally think that many physicians work at half capacity, and bringing the physician workforce into better balance with its potential will make it a more productive and happier profession. Or as Pogo might have said, "If life deals you lemons...make lemonade." ■

Doctor McCabe is MSMS president.

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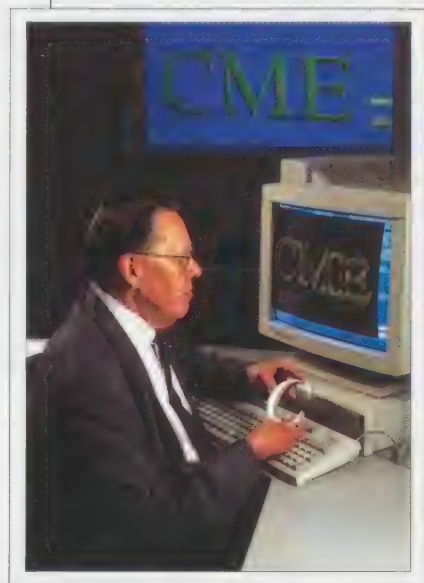
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COVER STORY



Re-engineering CME

24

The planners of continuing medical education in Michigan and around the country, including MSMS, are rethinking and redesigning their presentations to take advantage of new technologies and to meet physicians' future needs. Our cover story this month allows several experts to look at the possibilities teleconferencing, the Internet and other versions of "distance learning" provide for their field. With prudence and an eye to the goal of improving patient care, they also review the early beginnings of CME and the directions medical education has taken in recent decades.

By Karen Bouffard

Cover photo by: Roger Hill

FEATURES

PHYSICIAN WELL-BEING

Advice for preventing sexual misconduct charges

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A former Michigan physician cautions his colleagues about the pitfalls of medical practice that can lead to charges of sexual conduct, and offers his own suggestions for avoiding even the hint of such behaviors.

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Brian McCardel, MD

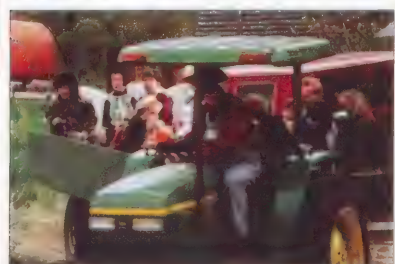
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East Lansing orthopedic surgeon creates on-line physician consultation service

By William Kendy



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PHYSICIAN VOLUNTEERS

Local Heroes

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This photo layout spotlights 14 Michigan physicians nominated by their county medical societies for MSMS awards recognizing their outstanding community service.

MAKING THE ROUNDS

MSMS/MPMLC program a great success

32

MSMS/MPMLC staff have met Michigan physicians on their own turf in 36 hospitals around the state. Another 16 "Making the Rounds" sessions are scheduled in future months.

MSMS ALLIANCE

Physician spouses help communities

34

MSMS members' spouses serve their communities in a variety of projects from collection and donation of medical supplies to support of Meals on Wheels; a photo feature

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By Ralph D. Ward

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Question:

“How do you open lines of communication with your patients?”

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Samuel R. Dismond, MD
Family Practice, Flint

“I sit down, look them in the eye, and really listen to what they are saying to me.”

Timothy C. Mead, MD
Orthopaedic Surgeon, Muskegon

“It depends on the age of the patient. For the infants I provide an open and non-judgmental attitude with the parents because they are the ones who can tell me what is going on. With toddlers I take the time to get close to them. I do this by talking to their parents while moving closer to the child. I then sit by the toddler. With adolescents I promise them that the conversation is between us if they don't want the parents to know. I let them know that I am there for them also as a friend and they can call me when they need me. Have to earn their trust.”

Felissa B. Kreindler, MD
Pediatrician, Birmingham

“You have to be open and friendly. Initial greeting is key because you have to convey somehow or another that you're there as a friend. To convey that I am really listening I sit down, rather than stand. Use soft body language. Over the years I've learned phrases and greetings in different languages. I greet patients this way if they are from a foreign country and it helps break the ice, especially if they are a new patient. It also makes them feel more comfortable.”

David A. Milko, MD
Otolaryngologist, Kalamazoo

“See them as the person that they are first, rather than as a disease entity. I make it a practice of listening after I ask

a question. After everything has been covered, I ask them if they have any questions or concerns that haven't been addressed. Many men who come in are somewhat hesitant to tell me any problems they are having, so I ask them what their wives are concerned with. This gives them the chance to answer without them feeling like they are whining.”

Linda D. Norrell, MD
Family Practice, Flint


“I personalize the conversation with the patient prior to discussing medical matters. Spend a short period of time getting to know the patient and the family. Pick non-controversial topics like hobbies, travel, sports.”

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“The toughest patients to communicate with are those who aren't big talkers and don't say what the problems are. With these people, I confront them and tell them we are not communicating effectively. Then I ask them if they have a problem with my personality, or me and what I can do to help open the lines of communication.”

Kim Zielke, MD
Internal Medicine, Geriatrics, Midland

BackTalk is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, BackTalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490.



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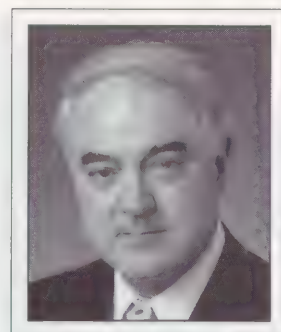
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Hospital Purchases of Physician Practices

By Richard D. Weber, MSMS Legal Counsel



Q: I have a family practice in a mid-sized, central Michigan community. The local hospital has been interested in purchasing my practice and I have so far resisted. Due to my age and concerns in dealing with the managed care environment, I am reconsidering. I have been told that there are some laws that would directly affect the sale of my practice to the hospital and particularly the amount of the sale. Can you enlighten me?

A: This is an extremely complicated area and this short column can only apprise you of the general concerns and give you some suggestions.

Both the Internal Revenue Service and the Department of Health and Human Services may scrutinize the acquisition. This interest on behalf of the regulators stems from a concern that any good will paid as part of the value may violate federal anti-kickback legislation, which forbids payment for the referral of Medicaid or Medicare patients. Violation of this federal legislation is a felony punishable by a fine up to \$25,000, five years imprisonment and loss of future rights to Medicaid and Medicare reimbursement.

This anti-kickback statute raises the question as to how to value your practice. Obviously, your practice, whether a professional corporation, partnership,

limited liability company or sole proprietorship, owns computers, desks, chairs, instruments and other hard assets that can be sold for a fair market value. It is unlikely, however, that these tangible assets would represent a very large part of the true value of the practice which is service-oriented and probably has a cash flow totally unrelated to these tangible assets. The real value of a physician's practice includes the intangible assets such as reputation, patient loyalty, patient files, going concern, and the prospect of future earnings. The regulators, particularly HHS, are opposed to valuing physician practices in excess of the fair market value of tangible assets and therefore such a sale may draw the attention of that agency. Payment for intangible assets, according to the regulators, could be considered possible payment for referrals.

Q: Obviously, if I sell my practice to the hospital, I will want to get the true value of the practice, not simply the fair market value of the tangible assets. Do you have any suggestions?

A: I suggest that you employ a qualified independent appraiser who should provide a well-documented evaluation of the true value of the practice as a going concern. This valuation can be used to rebut the allegation that you received payments for referrals. This appraisal should include fair market

valuations of tangible assets and the values for as many specific intangible assets as possible. The terms of the deal should be structured so that payment is made in a relatively short amount of time, and no provisions should be made for contingent payments based upon performance. Payments over a long period of time could be construed as payments for referrals. It would also be wise to keep records of referral patterns before and after the transaction if that is possible. This could be used to demonstrate that the transaction has had no extreme impact on referrals.

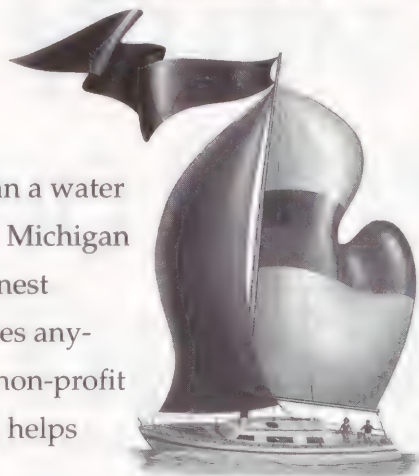
It is important to retain proper legal counsel to advise you with respect to the federal fraud and abuse laws and other laws applicable to this transaction, in addition to drafting a proper acquisition contract. Many physician acquisitions also include an employment contract between the hospital and the physician. Although this is beyond the scope of your questions, it is equally important to have competent legal advice relative to the employment contract. ■

Mr. Weber is a senior member of Kerr, Russell & Weber, PLC.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to Betty McNerney, Editor of Publications, PO Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or E-mail them to bmcnerney@msms.org.

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Electronic Mail Discussion Groups

The Internet provides thousands of discussion groups via e-mail by allowing users to place themselves on electronic mailing lists. A listserv (pronounced List Serve) is a program that maintains one or more of these mailing lists (via a list server). A listserv automatically distributes an e-mail message from one member of a list to all other members on that list. Listservs maintain thousands of lists in the form of digests, electronic journals, and discussion groups.

In order to give physicians a forum for electronic dialog, MSMS has begun developing a listserv program

with Voyager Information Networks. Among the topics covered will be Capitation News, Immunization News, Information from the Outstate Caucus, and MSMSNET Internet Training.

To subscribe to an MSMSNET mailing list, you send an e-mail message to the list server which automatically adds your name and e-mail address to the list. You will receive a letter of welcome via e-mail from MSMS telling you about the list. From that time on, you will receive all mail sent to the list by its members. You may follow the discussions or join in on them. If you

respond, you can send your response to the list (in which case, all members of the list will receive it), or to an individual on the list. You can also signoff or unsubscribe from a list at any time by sending an e-mail to the list server. In addition, you can receive a listing of all the members of a list and their e-mail addresses. Listserv access will be limited to Michigan physicians to eliminate the potential for abuse by others outside the system.

Look for MSMSNET Listserv access information online at <http://www.msms.org> or in *Medigram*.

Plug In a New Look for Netscape

Plug-ins are software programs available from Netscape and other software vendors that extend the capabilities of Netscape Navigator version 2.0 and above by giving you, for example, the ability to play audio samples or view video movies from within Netscape. Software companies are developing plug-ins at a rapid rates. Some of those most

interesting are Shockwave, RealAudio, and Acrobat Amber Reader. These files install quickly, and most download in 5 minutes or less over a 28.8k baud Internet connection. Plug In programs for Netscape 2.0 can be found at http://home.netscape.com/comprod/products/navigator/version_2.0/plugins/index.html/

"Surfing the Internet" is a monthly feature of Michigan Medicine. If you have a question regarding the Internet, the MSMS home page, MSMSNET, or Voyager Information Services, contact Andrew T. Clay at MSMS via E-mail at aclay@msms.org or by phone at (517) 336-7601.

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Advice for preventing sexual misconduct charges

By a former Michigan physician

In September 1993, a former patient filed a lawsuit alleging sexual misconduct against a family physician in practice in Michigan for 22 years who previously had no complaints of inappropriate behavior. Though the suit was voluntarily dropped three months later, its existence was published in the newspaper. The physician's office was picketed by an activist women's group who later entered the town parade where the doctor's wife, who happened to be the mayor, was marching. Massive media attention ensued and a call for "all women" to file complaints was made. Four women filed complaints with the Michigan licensing board.

Two agonizing years later, after five months of hearings there was no apparent end in sight. Media attention continued to be intense and painful. The physician's life savings were exhausted. Though his practice actually was growing, he was informed that his contracts with third party payers would be canceled for failure to resolve the allegations. His wife had developed stress-related bowel disease which required IV hyperalimentation. He felt the situation mandated a resolution and he ultimately accepted a suspension of his license. His family has since moved from the area to seek new career opportunities and peace. What follows is the physician's message of advice to colleagues following his ordeal.

The allegation of sexual misconduct in today's society is so inflammatory that we can no longer think in terms of defending ourselves against such charges; we must prepare pro-actively to prevent even a single allegation. One allegation can and did devastate my career and my security, and threatened the welfare of my family. Sobered by this tragedy I am rebuilding my career; but I

would like to help others to avoid this situation.

Physicians share a professional identity in which we feel commitment toward the welfare of our patients and receive great satisfaction in helping them. We try to understand their problems and to seek any opportunity to be of assistance to them. It is not in our nature to question ulterior motivations or sexually directed feelings when the patient has presented with medical problems which we are happy and able to treat.

In my residency I was trained to be open and non-judgmental in listening to my patients, to allow the patient to express moral, ethical, and cultural views which might differ from mine in order that the patient not be prohibited from full expression of symptoms and feelings. We would then supposedly be able to lead or redirect this patient to a more acceptable, happy, and healthy lifestyle.

Ideally, we would like to be accessible and cost-effective for our patients, so we see them after hours and in situations where regular staffing is not possible. We take shortcuts in protocol for the patient's benefit.

We understand the importance of a caring approach to patient care and sense that at least part of the patients respond favorably to the touch of a hand or even a hug. Some of us feel comfortable enough to share stories of our family lives with our patients with an anticipation that the patient also will feel free to express their deeply held feelings and values, or feel reassured

"Place your family first. Never forget that the decisions, policies, and conduct in your office may result in adverse consequences for your family back home."

by shared experiences.

Sometimes we would like to protect our patients from the harm which we know can occur from the notes we incorporate in the patient's chart. It is easy to omit potentially embarrassing statements and situations related by the patient, especially when confidentiality is requested. We want the patient to be willing to give us all the information necessary for their treatment.

These professional attributes and strategies can indeed lead to many therapeutic successes and to tremendous professional satisfaction as they did for me for 22 years. A single allegation, however, led to such painful consequences that I have rethought my entire approach to medicine.

We must seek to protect ourselves

Place your family first. Never forget that the decisions, policies, and conduct in your office may result in adverse consequences for your family back home.

Trust your gut feelings. If a patient makes you feel uncomfortable or manipulated, or obliged to treat them differently than what seems appropriate, respect those feelings. Don't try to rationalize them, but consult with someone else, eg. nurse, colleague, or spouse.

Empower your nurse to protect you. A nurse frequently may see behavior which you have failed to identify as manipulative or inappropriate. Encourage the nurse to speak to you about such observations.

Don't compromise your moral values. If a patient talks or behaves in a way which conflicts with your moral or ethical beliefs, you do not have to tolerate it. It is, in fact, dangerous to your personal and family security to do so.

Beware of the too-nice patient who may be friendly and solicitous, who seems to appreciate your care very much and "needs" your attention more than expected, who makes you feel irreplaceable. These patients are not bad people but they are dangerous. They may make you feel good, important, and appreciated, but they may be interpreting your enthusiastic medical concern

and caring response totally differently than you intend. These relationships may be difficult to cool because they often seem like friendship, but you have to protect yourself. Some people will get upset, but a true patient will understand.

An overt request for sexual favors cannot be tolerated. If the patient directly requests sexual attention from you, thank them for their frank honesty, and then discharge them immediately! This may not be a bad person confronting you, but he or she is a time bomb. This is no time for personal counseling or understanding. Send them to someone else.

Don't keep secrets for your patient. Unfortunately in this age of litigation, the possession of sensitive information which has not been recorded, makes the doctor responsible for implications regarding that secret. Do you really want that risk for you and your family?

Chaperons reduce risk of allegations. It took me 22 years to recognize that the presence of a nurse during a pelvic examination was for the doctor's protection, not the patient's. Of greater concern, however, are the visits which traditionally do not have chaperons. I believe that counseling situations are potentially more dangerous than pelvic exams, especially for family physicians, where physical examination is often required for the evaluation of problems requiring counseling.

General advice for avoiding allegations

- Spend time with your family.
- Talk with your spouse. Discuss your fears and failures as well as your strengths and accomplishments.
- Men, develop close male friendships in which you can share concerns and encourage and support each others' integrity. Love and support your wives. Consider joining Promise Keepers.
- Avoid fame and notoriety, if possible.
- Beware of pride and arrogance.
- Avoid public displays of wealth.
- Be vigilant to the danger.
- Pray for strength and guidance. ■

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for failure.
Allegations
can occur
despite your
best efforts."**

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June has been declared "Delta Dental Month" by MSMS. Member physicians and

ance program to enroll in Delta. Access to quality benefit plans can be a real bonus, by helping physicians recruit and retain quality employees. The plan, administered through the MSMS

To learn more about the MSMS Delta Dental plan, refer to the enrollment information mailed to you recently, call the MSMS Group Insurance Trust at 1-800-748-0195, or visit the MSMS Internet Home Page at <http://www.msms.org/> and click on Group Insurance Trust.

their employees are encouraged to take advantage of this once-a-year opportunity to join this MSMS-sponsored dental program.

The Delta plan is a "free-standing" benefit. Physicians and their employees do not have to participate in any other MSMS endorsed insur-

Dental Benefit Comparison

The following chart indicates the services covered by Delta Dental Plan of Michigan through the MSMS-sponsored dental benefits program, as well as the percentage of coverage of the contracting dentist's usual/customary fee for each category:

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Radiographs		
As required, and in conjunction with the diagnosis of a specific condition requiring treatment.	100%	0%
Oral Surgery		
Includes extractions and other oral surgery procedures usually employed by a dentist, including pre and post operative care.	50%	50%
Restorative		
Includes amalgams (silver fillings), synthetic porcelain, plastic restorations, relines and repairs to prosthetic appliances. Gold restorations, crowns, and jackets may be used, but only when the teeth can't be restored with another filling material.	50%	50%
Periodontics		
Procedures usually employed by a dentist for the treatment of diseases of the gums and supporting structures of the teeth.	50%	50%
Endodontics		
Procedures usually employed by a dentist for the treatment of non-vital teeth (i.e., root canals).	50%	50%
Prosthodontics		
Includes procedures required for the correction of bridges, partial and complete dentures.	50%	50%
Orthodontics		
Treatment and procedures required for the correction of malposed teeth. Eligible persons are covered only to age 19.	50%	50%

Benefit Maximums

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Brian McCardel, MD

Doctor McCardel's "Curbside" creates on-line consultations

By William Kendy

"Curbside", the brainchild of Brian McCardel, MD, an East Lansing orthopedic surgeon, affords physicians not only the opportunity to consult with their counterparts across the state and the country, but also access to a host of communication and information options.

Doctor McCardel conceived the idea two years ago after his wife, an avid Internet "surfer," told him that she could find more information online about the care and feeding of her roses than he could on caring for his patients.



"At the time, she was right," says Doctor McCardel. "I started thinking about that and one thing led to another. We began looking for a way to provide geographically dispersed physician communication."

Computing for Doctor McCardel was nothing new. He has been intrigued by computers since the mid-70's, spending hours in front of a keyboard and printer in high school.

"I used to access the MSU main-frame," says Doctor McCardel. "I spent a ton of time just playing around with it."

Partnering with Lansing entrepreneurs, Doctor McCardel set up Medical Net, Inc. in 1995. He and started work on developing an on-line service, exclusively for physicians, that would provide help needed to effectively and efficiently practice medicine and stay on top of current medical developments.

In that process, Doctor McCardel found that many physicians are not overly involved with computers, nor are they aware of the extent that they can be used as an efficient professional tool.

"Many doctors don't see a great deal of utility in computers," says Doctor McCardel. "They view them as boxes in the corner, used purely for billing."

Doctor McCardel designed Curbside to "take the box out of the corner". Curbside provides a number of directly accessible services including Curbside Consultant, Teleradiology Uplink, Internet Access, Physicians Lounge, Library, Mail and a Personal Information Manager.

According to Doctor McCardel, Curbside Consultation allows two (or more) physicians to discuss, without ever meeting each other face to face, specific treatments for patients. Physicians can use Teleradiology Uplink to transfer high resolution medical images on a "real time" basis. A doctor can literally share X-Ray images with another doctor for advice on treatment.

"The really exciting aspect of very high speed networks is the ability to send high quality radiographic images directly to the contact," says Doctor McCardel.

In addition to direct communication with

other physicians, Curbside offers access to the Internet, a physicians' "chat room," E-mail and a library feature, which allow physicians to pull up information from medical textbooks, journals and publications. Finally, the personal information manager can be designed to automatically access only those topics, forums and columns of specific interest to each physician and displays them immediately once that doctor logs on to the system.

"Our goal is to become a one-stop information shop for physicians," says Doctor McCardel. "For example, the personal information manager is designed to allow physicians to get the most information in a condensed form with the least amount of searching."

According to Doctor McCardel, the continuously changing and evolving health care industry, which took doctors from a fee-for-service basis, to health care organizations and now to IPAs, PHO/POs and MSOs, all contribute

to the need for Curbside.

"There's a strong drive on the part of physicians to gain control of their lives and to form groups large enough to have economic clout," says Doctor McCardel.

"To my way of thinking, 70 doctors spread out over 30 offices can have control," says Doctor McCardel. "We more and more perceive ourselves as one large entity, with branch offices. And it makes sense to coordinate our efforts over an electronic platform."

To insure security, each physician is assigned a personal number that allows them to access the system.

What does Doctor McCardel see for the future of Curbside?

"There are approximately 650,000 practicing physicians in the United States," says Doctor McCardel. "I'd be very happy if we could sign up 50,000 users." ■

The author is a Holt, Mich.-based freelance writer.

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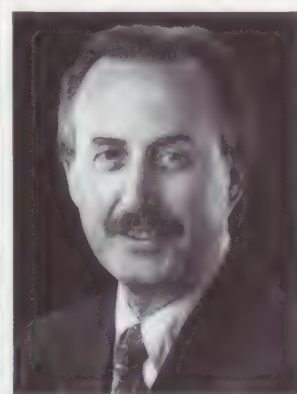
MSMS honors fourteen physicians for outstanding community service

Think globally, act locally. Or, think globally, act globally. Whatever their philosophies, fourteen Michigan State Medical Society members provide a mix of local/global volunteer work that won them 1996 MSMS Community Service Awards. They work in schools to teach children about the dangers of drugs, alcohol and tobacco use. They provide medical services for the homeless and indigent. They provide expertise in hospices. Others give back to their native communities in India, the Philippines and Mexico. Still others...well, read on.

Paul L. Brothers, MD, of Sturgis, is honored for his involvement in numerous medical and community activities during his 40-year career. Recently retired, Doctor Brothers helped found the first coronary care unit in the Sturgis area. He is 70 years old.



William R. Church, MD, of Traverse City, is recognized for his ongoing efforts to supply Third World hospitals with ultrasound equipment. A diagnostic radiologist, he has made seven trips abroad since 1989 to deliver equipment—which he arranged to be donated—and to train local physicians on how to use it. He is scheduled to go to Bangladesh this year.



Rajendra Bothra, MD, of Warren, is cited for his commitment and personal leadership to improve medical care in his native India. The Warren surgeon, awarded the Medal of Merit by President Reagan, has raised more than \$1 million and helped start two foundations to address the problem. Doctor Bothra spends about eight weeks in Bombay each year treating the poor, those with AIDS, and others. His work for social issues around the world has included audiences with Rajiv Ghandi, President Bush, Pope John Paul II, and Mother Theresa.



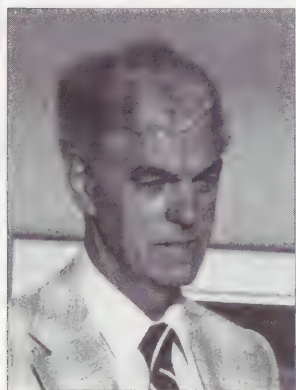
Peter F. Gordon, MD, of Sterling Heights, is honored for his commitment and dedication to the prevention of drug and alcohol abuse and tobacco use. As a volunteer leader, Doctor Gordon is a founding member of the Troy Community Coalition for the Prevention of Drug and Alcohol Abuse and has remained active throughout the past five years. In addition, he serves as president of the Coalition of Healthy Communities which is a partnership of prevention coalitions in the neighboring cities of Birmingham, Clawson, Royal Oak and Troy.

William E. Nettleman, MD, of Tekonsha, earned the award for his distinguished record of volunteer efforts. Those included serving as a guest lecturer in local schools on science, medicine, beekeeping and other subjects. He also has been active in Boy Scouts, Rotary, and the United Way, and served for a number of years as the volunteer team doctor for Coldwater High School. Doctor Nettleman, who retired in 1985, helped found a hospice in Branch County.



William G. O'Driscoll, MD, of Ada, is honored for his dedication to providing medical care to the less fortunate. The Ada physician served on the task force that led to the creation of the Clinica Santa Maria six years ago. Doctor O'Driscoll has provided care on a regular weekly basis for the clinic's Hispanic and poor patients.

He also was on a team of physicians that went to the Dominican Republic in 1989 to treat the poor.



George H. Phillips, MD, of Jackson, is honored for using his personal triumph over alcoholism as the starting point for a professional focus on helping others fight the disease. Already an expert on chest and respiratory disease, Doctor Phillips, now 80, founded the Alcoholism Rehabilitation and Treatment Center at Foote Hospital in Jackson in 1973. Since then, the Center has helped thousands of people.



Ariston C. Sandoval, MD, of Mt. Clemens, earned the award for his leadership in four international medical missions, three to the Philippines and one to Mexico. The St. Joseph Mercy Hospital anesthesiologist helped treat hundreds of patients on each mission. Doctor Sandoval also worked to gather supplies and medicines for the missions. Another mission is in the works.



Robert C. Prophater, Sr., MD, of Bay City, is recognized for his lengthy record of civic leadership. He has served on the Saginaw Valley State Board of Fellows, and the United Fund Board of Directors, as president of the Bay City Commission, and as president of the Bay Area Chamber of Commerce. The 74-year-old general practitioner has been a member of the Bay Medical Center staff since 1958. He now holds the post of vice president for the Bay Health Systems Corporate Medical Services.



Helen J. Scoblic, MD, of Bad Axe, who has practiced in Huron County for 20 years, is recognized for her leadership and outstanding community service. An internist and endocrinologist who has practiced in Huron County for 20 years, Doctor Scoblic visits civic groups to speak about home care and the hospice program, to which

she also serves as a medical consultant. She teaches adult classes on diabetes mellitus and also gives talks to organizations and groups about osteoporosis and other female health issues.

David Alan Share, MD, of Ann Arbor, is honored for his leadership in community health services during his 15-year tenure as medical director of The Corner Health Center in Ypsilanti. The clinic serves more than 3,000 teen parents and their children, especially the poor. Doctor Share helped develop "A Star is Born" program to prevent child abuse and neglect by teen parents. In addition, he helped start a theater troupe to present health information to teens and to educate them about the clinic's services.



Glenn P. Verbrugge, MD, of Cadillac, is recognized for his humanitarian efforts in Africa and civic leadership in Cadillac. He worked as a surgeon in Nigeria for 10 years and returns to Africa one month every two years to teach doctors about various surgical procedures. Doctor Verbrugge was a leader in creating an ice skating rink in Cadillac and is working to produce an indoor ice hockey arena. He also serves as a hockey coach, as well as president of the Cadillac Rotary Club.



Daniel J. Wilhelm, MD, of Port Huron, is honored for his involvement in and dedication to child-related community activities. The Port Huron pediatrician serves on the local school board and takes part in the "lunch buddy" program, which pairs an adult with an inner city elementary school pupil. Doctor Wilhelm is active in the local March of Dimes, the Comprehensive Community Health Models of St. Clair County and a clinic that assesses attention deficit, hyperactivity and learning disorders. He also conducts numerous presentations and workshops on attention deficit disorders. ■

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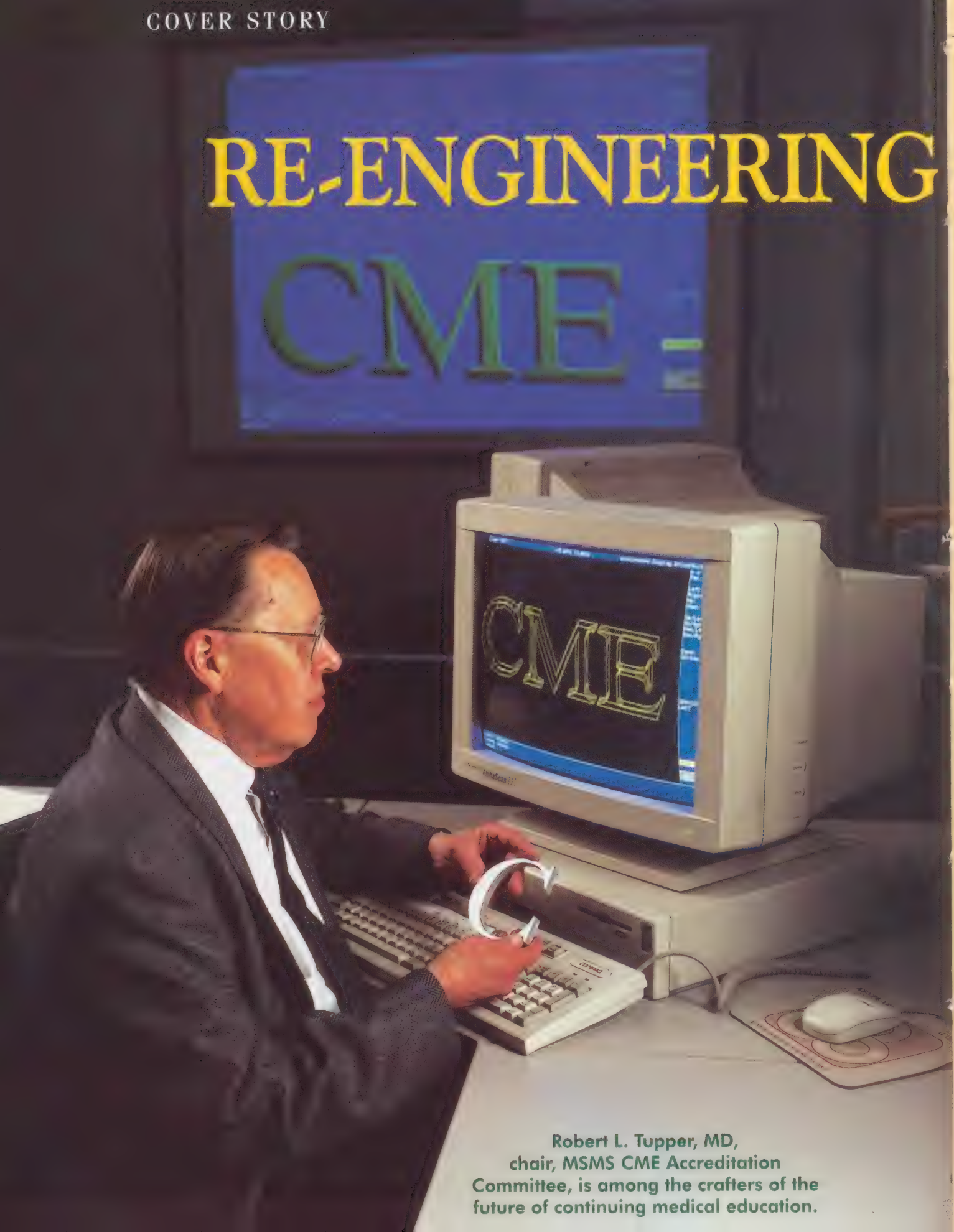
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RE-ENGINEERING CME

New Expectations for Continuing Medical Education

The evolution of continuing medical education has been somewhat akin to a roller coaster ride, its history marked by steady progress, but also by a few loops, dips and crazy eights. CME in Michigan, as in the nation, has taken shape in a process that formally began in the early 1960s, and gained considerable momentum in 1975. Now the structural engineers responsible for delivering CME are challenged by changes in the healthcare environment unforeseen 21 years ago; a mammoth and rapidly expanding knowledge base, the demands of managed care, and advanced technology. Here's what MSMS physician experts have to say about CME's past, present and future.



Robert L. Tupper, MD,
chair, MSMS CME Accreditation
Committee, is among the crafters of the
future of continuing medical education.

CME today looks to the future

By Karen Bouffard

Today, 29 Michigan institutions are accredited to offer CME programs, including 60 hospitals. In addition, institutions that offer less than 25 hours of CME each year can apply for joint sponsorship with MSMS or another accredited organization. Michigan is a national leader in the number of CME programs it offers.

Michigan is one of only about 20 states that requires CME for license renewal. The law requires 150 hours of CME related to the practice of medicine and medical ethics over a three year period. Seventy-five of these must be in "Category 1." When the statute was adopted, the legislature borrowed six categories of CME from the requirements of the AMA's Physician Recognition Reward: 1) accredited programs; 2) non-accredited programs; 3) teaching; 4) writing papers; 5) self-instruction/self-assessment or serving on utilization review committees; and 6) being a resident in training. In 1988, the AMA House of Delegates decided to recognize categories to include just Category 1, accredited programs, and Category 2, which includes the former categories 2-6. As a result, while for PRA purposes there are now only Categories 1 and 2, the Michigan relicensure process still utilizes six categories.

According to Tama Abel, MD, assistant medical director of Maple McAuley Urgent Care in Ann Arbor, Category 1 CME should be related to improving patient care. While in many states this requirement can be rather loosely construed, Michigan is strictly interpretive.

"Our programs aren't as loosely related to patient care as are some others," says Doctor Abel, a member of the MSMS CME Programming Committee, which jointly sponsors programs offered by non-accredited in-

stitutions. "Michigan is stricter than are many states. The idea of continuing medical education is that our first and foremost job is to take care of patients, so there has to be that link. When you're talking about the 'art of medicine' you're talking about patient care."

Doctor Abel adds, "When I go to programs out of state, sometimes it seems that they are really stretching their interpretation. People can and should go to other things, but not when it's tied to their license."

According to Rudi Ansbacher, MD, an OB/GYN at the University of Michigan Medical Center and member of the MSMS CME Programming Committee, "What we've seen happen is more and more courses given for topics which don't benefit patient care—such as those on billing. True CME should improve patient care."

Doctor Abel adds that the process has to be flexible enough to accommodate changes in the way medicine is practiced. "We have to be able to look at the life of a physician today, and that might no longer include the 'go to the office, work 10 hours and go home' kind of a day."

According to Steven E. Minnick, MD, a general internist and director of CME at St. John Hospital and Medical Center in Detroit, "We're constantly looking to the future to see how CME will be relevant and useful."

A member of the MSMS CME Accreditation Committee, and also of the Accreditation Council for CME, Doctor Minnick says, "We're always looking for ways to improve CME, looking at changes that are occurring, asking if the standards are relevant to today's environment."

Doctor Minnick says new pressures have been placed on CME by those specialty boards that now have time limited recertification, by the emergence of managed care, and by today's huge and ever-growing knowledge base—all of which



Tama Abel, MD



Steven E. Minnick, MD



have expanded the need for physician education.

"Before, physicians were board certified for life. Recently the specialty societies have imposed time limits, requiring physicians to retake exams to update their board certification," he says. "With our rapidly changing medical environment the knowledge has just skyrocketed. And as managed care looks at how patients are treated in terms of quality, cost and need, there will be a greater need for education."

A Look Back

According to Roland G. ("Red") Hiss, MD, a hematologist with the University of Michigan Medical Center and chair of the University's Department of Postgraduate Medical and Health Professions Education which has responsibility for CME programs, CME has been part of medicine since as early as the 1940s. At first it was known as "post-graduate education," but it didn't gain significance until after World War II.

"Today, 98-99 per cent of graduates of US Medical schools enter graduate medical programs. Prior to World War II most physicians did only a one-year rotating internship, and became 'general practitioners.' That was standard procedure," says Doctor Hiss, noting that Chicago in the 1940s had only one neurosurgeon. "Two things happened that changed all that -- World War II came along, and medicine got big.

"The general practitioner was a 'do-all-things' physician, but during the 1940s and '50s, medical science began to encompass too much for any one person to handle. "Then during World War II, for reasons of expediency, the military assigned physicians to do different things."

By the 1960s medicine had evolved to include specialty and sub-specialty areas, and in 1961 the AMA took on responsibility for accrediting organizations and institutions that wished to provide continuing education for physicians. The term "post-graduate education" became obsolete, and CME was born.

"CME was under the auspices of the AMA in the mid-60s, and in 1968 the AMA introduced the Physicians Recognition Award (PRA) to recognize those physicians meeting the requirements of CME," says Robert L. Tupper, MD, an internist who is Director of Medical Education/Medical Staff Office for Blodgett Memorial Medical Center. Doctor Tupper is past chair of the ACCME, has been a member of the MSMS Accreditation Committee since 1975, and is currently Chair.

According to Doctor Tupper, the AMA Advisory Committee devised standards in the late 60s. By the mid-1970s the number of organizations applying for accreditation became so great that the AMA modified its approach, retaining authority over national or regional programs while allowing state Societies to take jurisdiction for state and local programs.

In 1974, the MSMS House of Delegates formed the Commission on Continuing Medical



Robert L. Tupper, MD



Roland G. Hiss, MD

Education, known today as the MSMS Committee on CME Accreditation. It was approved as the accrediting body for CME in Michigan in 1975. Lansing's Sparrow Hospital became the first institution granted accreditation by the MSMS Commission, and Blodgett Memorial the second.

Partly as a result of the increasing numbers of malpractice lawsuits and rising malpractice insurance premiums of the 1970s, the national Liaison Committee on Continuing Medical Education (LCCME) was formed in 1977. "Somehow the idea got across that if we could tell the public we are advancing continuing medical education it would be like a 'Good Housekeeping Seal of Approval,'" Doctor Tupper says.

Responsibility for national accreditation was transferred from the AMA to the LCCME, which was composed of representatives of the AMA, the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC,) the Council of Medical Specialty Societies (CMSS,) the American Board of Medical Specialties (ABMS,) the Association for Hospital Medical Education (AHME,) and the Federation of State Medical Boards (FSMB.) In 1975, MSMS successfully pressed the Michigan Legis-

lature to amend the Medical Practice Act to require CME as a condition of license renewal.

According to Doctor Tupper, "things went along pretty well" until 1980 when, against strong objections by state medical societies, the LCCME vetoed approval of accreditation applications from institutions in four southern states. Amid heated debate, the AMA withdrew from LCCME and formed the Committee on Accreditation of CME (CACME,) of which Doctor Tupper was a member.

"For the next 15 months everybody

seeking national accreditation was applying to both the LCCME - which now had six parent organizations instead of seven—and to CACME," Doctor Tupper recalls. "Then, out of this cloud of dust emerged a compromise. The AMA dissolved CACME, and LCCME formed the Accreditation Council of CME (ACCME.) In a 'smoke-filled rooms' kind of atmosphere, to clarify that this was different, the old 'standards' for CME were dropped and 'the Seven Essentials' we use today were adopted. LCCME became ACCME, signifying a new era."

In 1993, FDA Commissioner David A. Kessler, MD noted abuses of CME by some companies, particularly from the pharmaceutical industry, which sought to influence physicians by using techniques such as offering posh travel arrangements and honoraria to presenters. Kessler urged organized medicine to adopt methods of avoiding conflicts of interest.

In response, ACCME adopted its "Standards for Commercial Support of Continuing Medical Education." These were procedures established to ensure the integrity of CME programs by requiring that accredited sponsors be sure CME activities are free of commercial bias. For example, money from pharmaceutical companies must be given to accredited institutions in the form of unrestricted grants, rather than to individual researchers or presenters; and speakers are required to sign sworn statements that no conflicts exists, or announce any potential conflict to the group before presenting.

CME of the Future

According to David Rovner, MD, chair of the MSMS Committee on CME Programming, a Michigan State University endocrinologist and assistant to the Dean for Technology in the MSU College of Human Medicine, CME has much to look forward to in the way of using advanced technology. But at present, Doctor Rovner adds, "Technology is way ahead of our ability to use it."

"Distance learning," for example, could greatly facilitate CME by reducing travel time between facilities. At MSU, where students are based at satellite facilities in six communities throughout the state, distance learning could be advantageous.

"A lot of instruction is done by faculty physicians in those communities, but there is also a lot of travel back and forth." Doctor Rovner says.

Mark your calendar!

The 1996 MSMS Annual Scientific Meeting is coming again to the beautiful new Lansing Center November 14-16.

"The location was convenient, and because it was in the middle of the state it allowed for contact with physicians from all over the state," said Pamela D. Johnson, MD, Rochester Hills, who attended the Annual Scientific Meeting in Lansing for the first time last year.

A full list of the meeting's Category I courses will appear in the June 27 Medigram. Watch these pages for more features on courses and speakers. For details, call Sarah Cressman at MSMS, 517/336-5727, or e-mail her at scressman@msms.org.

"Distance learning could establish links from one campus to another. These links could be used not only for distance learning, but for research and administrative data."

An impediment to distance learning, Doctor Rovner says, is scarcity of knowledge about how to make it interactive and effective. "The question is, how do we educate at a distance without boring people. Many distance education efforts have 'talking heads; which are even more boring on TV than in person."

"Technology ought to be a magnificent way of transmitting education, but so far we don't do that very well."

Doctor Minnick says medicine can learn more about how to use technology by studying school systems, such as those in the Upper Peninsula, which have experienced some success with distance learning projects. "Some of the best educational technology is in school systems," he says.

Doctor Minnick adds, "We also have much to look forward to with a lot of the computer technology that is available -- especially with CD ROM capability that provides sight and sound, as well as information."

"In the past, we would have had to see things at the bedside. CD ROM capability will allow people to interact in educational settings that we've not had before. Advanced telephone lines will provide many opportunities as well. Technology can evolve to where multiple groups are conferencing together, with all learning in real time as a group."

Distance learning, computer technology, CD ROMs, the Internet, all create greater opportunities for self-directed or individual learning. According to Doctor Tupper, a member of the Strategic Planning Committee of ACCME, soon-to-be adopted changes in the accreditation process will address this issue, as well as other trends.

"As early as 1997 or 1998," Doctor Tupper says, "institutions being resurveyed will be able to apply for basic standard accreditation, and separately for 'certificates of added qualifications.' One of these certificates will be for accreditation of individualized learning projects."

Other certificates of added qualification will be available for joint sponsorship of CME programs, and for accreditation of enduring materials. "We need to develop a quality assurance approach to make sure that accreditation decisions are proper," Doctor Tupper says. "In the case of joint sponsorship, the 'rubber stamp' is not

enough; enduring materials, such as computer tapes, textbooks and CD ROMs need to be dated—and we need to demand proof that the accrediting organization has examined and approved the material."

Regardless of what the future brings, Doctor Abel says she believes CME is here to stay. "I think we'll still have to maintain our education post-residency," she says. "I don't see that we'll have less education mandated. Whether it will be tied to licensing, or perhaps to board certification instead, remains to be seen."

According to Doctor Rovner, studies have been done over the years to determine the effectiveness of CME programs by looking at ways physicians practice medicine both before and after attending CME.

"There's no question that how physicians practice medicine changes over time -- probably due to a combination of CME courses, journal reading, influential physicians in a region and drug detail people."

"Something in all of these things does change behavior, and I would be loathe to change any of it," Doctor Rovner adds. "You don't want to throw the baby out with the bath water."

Thus, the planning for the future of CME continues. There is no doubt that the re-engineering will change the structure of CME offerings. But with the good and careful crafting of leaders like Doctors Abel, Hiss, Minnick, Rovner and Tupper, CME will continue to follow the goal of ever-improving patient care. ■

The author is a Williamston, Michigan-based freelance writer.



David Rovner, MD

Physicians' CME requirements in Michigan

The Michigan Public Health Code requires physicians to complete, during the three-year period before application for license renewals, not less than 150 hours of continuing medical education in courses or programs approved by the Board.

The Board of Medicine has established six categories of approved CME. The following is a brief description of each category and the number of allowable hours which may be earned in each category during the three-year period preceding license renewal.

- Category 1 - Minimum credit hours: 75 hours in three years
Continuing medical education activities with accredited sponsorship including medical ethics; specialty board certification/recertification.
- Category 2 - Maximum credit hours: 36 hours in three years

Activities with nonaccredited sponsorship. (As applied for and approved by the Board)

- Category 3 - Maximum credit hours: 48 hours in three years
Teaching physicians or allied health practitioners.
- Category 4 - Maximum credit hours: 48 hours in three years
Writing books, papers, publications and preparing exhibits.
- Category 5 - Maximum credit hours: 36 hours in three years
Three areas, 18 maximum hours in any one - Self-assessment, self-instruction and quality care or utilization review
- Category 6 - Maximum credit hours: 50 per year

Full-time participation in graduate training program of at least five full months per year in which credit is claimed.

MSMS has two key committees helping direct developments in Michigan physicians' continuing medical education. The committees and their members are listed below:

Committee on CME Accreditation

Robert L. Tupper, MD, Grand Rapids, Chair
Raakesh C. Bhan, MD, Battle Creek
Robert O. Bollinger, PhD, Detroit
John F. Casey, MD, Taylor
Allen D. Damschroder, MD, Petoskey
Howard J. Dworkin, MD, Royal Oak
Norbert B. Enzer, MD, East Lansing
Mark I. Evans, MD, Detroit
James W. Gell, MD, Bloomfield Hills
Ved V. Gossain, MD, East Lansing
Ernest M. Hammel, PhD, Southfield
Roland G. Hiss, MD, Ann Arbor
Paula J. Kim, MD, Grosse Pointe
Paul A. Lazar, MD, Flint
Nicholas J. Lekas, MD, Dearborn
Billie Lewis, MD, Flint
David J. Millard, MD, Paw Paw
Steven E. Minnick, MD, Detroit
Robert K. Richards, PhD, Grand Rapids
Shari L. Rietberg, Grand Rapids
Jan Rival, MD, Bloomfield Hills
Victor V. Rozas, MD, Alma

Richard H. Smith, MD, Detroit
Narendra Tyagi, MD, Waterford
Vernon E. Wendt, MD, Grand Rapids
Richard F. Willis, MD, Alpena
Charles L. Zeller, MD, Kalamazoo

Committee on CME Programing

David R. Rovner, MD, East Lansing, Chair
Tama D. Abel, MD, Ann Arbor
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Troy
Eugene A. Dolanski, MD, Mason
Fereshteh Fahimi, MD, Lansing
Clyde R. Flory, MD, Lansing
Dorothy M. Kahkonen, MD, Detroit
John G. McHenry, MD, Northville
David J. Millard, MD, Paw Paw
Bassam H. Nasr, MD, Port Huron
Mary Elizabeth Roth, MD, Southfield
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36 hospitals visited so far

MSMS/MPMLC program a great success

The MSMS/MPMLC "Making the Rounds" program begun in 1995 has been an outstanding success. Medical society/insurance company staff ambassadors have taken their programs to medical staffs of 36 Michigan hospitals, making direct contact with more than 5,000 Michigan physicians. Another 11 "MTRs" are scheduled during 1996 and three already are set for spring of 1997. The purpose is to bring MSMS/MPMLC services and products to MSMS members (and non-members) on the physicians' own turf.

"It was great to have MSMS and MPMLC experts available to us for a whole day." "Who are you again--The MSMS MTR Team? I've been an MSMS member for years and I have never met anyone from MSMS." Those are some of the comments the "Making the Rounds" program has generated from physicians around the state. MTRs include visits with individual physicians, demonstrations of MSMSNET/Internet possibilities, and speakers for medical staff meetings. To arrange an MTR at your hospital, contact F. B. "Tom" Plasman at MSMS headquarters. (Phone 517/336-5724, fax Tom at 517/337-2490, or e-mail him at tplasman@msms.org.)



Medical staff visit the Making the Rounds display in the lobby at Saratoga Community Hospital April 2.

Andy Clay, MSMS chief of computer operations, demonstrates the features of the MSMSNET site on the Internet to Saratoga Community Hospital physicians Suthin Liptawat, MD, chief of surgery (seated) and Chakradhar Reddy, MD, chief of medicine.





On March 11, MSMS Board member Thomas E. Stone, MD, described the importance of the '96 Michigan Supreme Court elections to the West Shore Hospital medical staff and Manistee County Medical Society.



Doctor Stone, center, is among MSMS directors becoming active with the program. He is flanked here by Manistee County Medical Society President Charles J. Poposki, MD, left, and Daniel D. Joseph, MD, West Shore Hospital staff.

Sixteen MTRs scheduled

MSMS and MPMLC have scheduled "Making the Rounds" programs over the coming months at the following 16 hospitals.

1996

Mercy Memorial, Cadillac	August 12
Sturgis Hospital, Sturgis*	September 10
St. Mary's, Grand Rapids	September 17
Oakwood, Dearborn*	September 24
Pennock, Hastings	October 10
Muskegon Mercy	November 20
Community Memorial, Cheboygan*	Fall
W. A. Foote, Jackson*	Fall
Tolfree Memorial, West Branch*	Fall
Saginaw General	Winter
St. Mary's, Livonia	Winter

1997

St. Mary's, Saginaw	January 10
Henry Ford, Wyandotte	March 26
West Shore, Manistee/ Memorial, Ludington	August 11
St. Lawrence, Lansing	Fall

*Second program at this site.

Physician spouses serve

Variety of projects underway in local communities

MMSMS Alliance members from across the state, covering 26 counties, are leaders on local health and education projects. The photos below demonstrate the depth and breadth of Alliance contributions over the past several months.



Northern Michigan Alliance President-elect Dree Lo, left, and President Joanne Deckinga, right, presented groceries and gifts from their chapter for a needy family at Christmastime. Accepting the Alliance donations is Vasco Zucchiotti, Charlevoix County Social Services Department.



Grand Traverse Alliance members have shared "I Can Choose" coloring books with local youngsters like kindergarten Jennifer Schanz, above. The coloring books were produced by the AMA Alliance, and help children develop healthy habits for a lifetime.



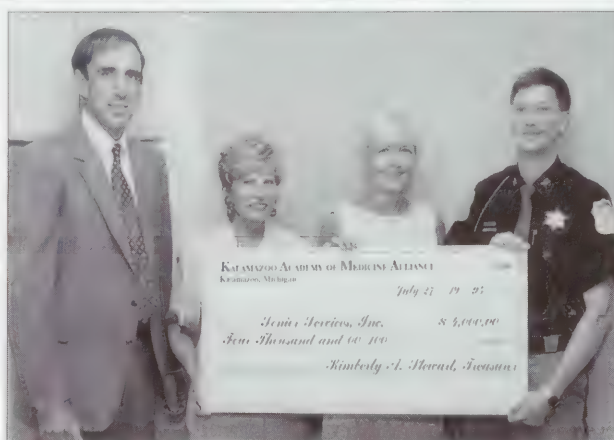
MSMS Alliance representatives share their success in community activities at the annual AMA Alliance Confluence conference in Chicago. At the most recent conference, from left, were Kandace Boysen, Muskegon; Jean Howard, MSMS Alliance immediate past president; Janet Rosenthal, Oakland; Deborah Pack, Genesee; Janet Gregory, MSMS Alliance President; Marianne Delavan, Kent; Dree Lo, Northern Michigan and Lynn Schultz, Grand Traverse. All are current county presidents except for Jean and Jan.



The Genesee County Alliance held a Halloween party for young members and their children. The party included a hay ride around the Streibel farm in Linden.



Twenty Kent County Alliance members collected more than 30 boxes of medicines and supplies for their Annual Drug Pick Up project in March. The project supplied medical equipment for International Aid, a station wagon-full of medicines and supplies for Heartside Clinic in downtown Grand Rapids, six boxes of baby formula, birth control pills and antibiotics to Booth Family Services, and insect repellent, cold medications and soap to Child Haven in Grand Rapids. Nancy Struyk and Carolyn Welch are project co-chairs.



D--Marylin Milko, president (second from left), and Sharon Kokales, Finance Committee chair, presented a Kalamazoo Academy of Medicine Alliance check for \$4,000 to Robert Litke, executive director, Senior Services, Inc., (left). Also at the presentation was Thomas Edmonds, Kalamazoo County Sheriff and chair of the board for senior services. The money will be used to help build the Pauline Allen Nutrition Center to expand the Meals-on-Wheels program serving the homebound of all ages.

Mitchell A. Rinek, MD

The Brewmaster's Art

By Ralph D. Ward

Consider the ways beer and medicine have interacted in history. For centuries beer was valued for its therapeutic effects. More fundamentally, the chemical process involved in fermentation is actually a biological one. Beer is alive.

Mitchell A. Rinek, MD, a Lansing dermatologist, has long been fascinated by these and other aspects of the brewmaster's art. I've always been intrigued with beer...it's a democratic beverage," he observes. And from a medical view, he respects brewing's history. "Beer recipes go back to the age of Mesopotamia and Sumeria."

lore for suds fanciers. "It brings civilians in beer together with experts," says Doctor Rinek.

The camp was typical of those offered to beer fanciers, with 10 to 14 attendees walked through the fine points of malted beverages by a seasoned writer on the subject. "They can tell you whether a beer is good or awful," recalls Doctor Rinek.

Doctor Rinek put his interest to work last year by attending a "beer camp" held at the Oldenberg Brewery in Fort Mitchell, Kentucky. One of the growing number of micro-breweries around the country, Oldenberg offers a week-long session on tasting and brewing

Certainly beer campers had enough options. "We had an option to taste over 320 beers, from draft to bottled, from XXX stouts to light lagers."

Doctor Rinek came away with a greater understanding of the brewer's art. "Most who are in medicine are interested in the biology of the beer process, the various aspects of fermentation and carbohydrates. There is a lot of subtlety in beer." Doctor Rinek also notes that medical training makes him more aware of the physical damage overindulgence can cause.

Doctor Rinek hopes to try his hand at home brewing one of these days, but for now limits his tastes to exploring the more exotic beers available from across the world. His current favorite? Heffe-Weise, a wheat beer. "It's a unique, acquired taste." ■

The author is a Riverdale, Michigan-based freelance writer.



Doctor Rinek, right, became interested in "beer camp" after hearing of it from colleague David K. Johnson, MD, left, a Lansing urologist. Both display favorite brews above. Doctor Johnson's is one of his own making.

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Sault Ste. Marie*

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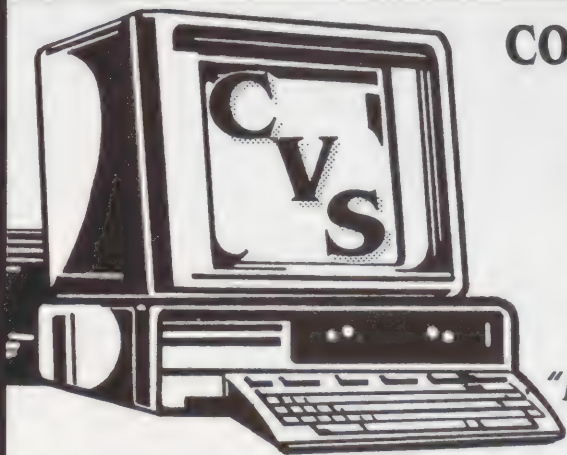


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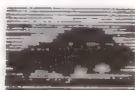
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Susan Schooley, MD, chair of the Department of Family Practice,



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(PPAC), a national committee that advises on Medicare and Medicaid policy. The council, composed of at least 11 physicians and up to four other health care professionals, meets quarterly to advise on proposed changes in Medicare and Medicaid regulations related to physician services. Recommendations of the Council are forwarded annually to the Health and Human Services Secretary and the administrator of the Health Care Financing Administration.

Samuel Dismond, Jr., MD, chief of staff at Hurley Medical Center, president-elect of the Genesee County Medical Society and president of the African-American Physicians Association of Genesee County, is the recipient of the Donald Riegle Community Service Award. The award was established in honor of the former U.S. senator who was active in helping Jews to leave the Soviet Union. ■

Deaths

Manley L. Barry, MD, a Plainwell psychiatrist, died April 9, 1996, at the age of 82. Doctor Barry was a 1943 graduate of the Boston University School of Medicine. He had been affiliated with Kalamazoo's Bronson Methodist and Borgess hospitals and with the Plainwell Sanitarium.

Geo E. Braunschneider, MD, a Grand Rapids family physician, died March 25, 1996, at the age of 75. A 1953 graduate of Marquette University Medical School in Wisconsin, Doctor Braunschneider was affiliated with St. Mary's, Blodgett and Butterworth hospitals in Grand Rapids.

John S. DeTar, MD, former speaker of the MSMS House of Delegates, died March 18, 1996. A 1930 graduate of the Wayne State University School of Medicine and a Milan general practitioner. He was 94. Doctor DeTar held many professional posts throughout his career including: member of the Board of Directors of Blue Shield of Michigan; president of the Michigan Health Council; president of the American Academy of General Practice; and member of the Michigan Delegation to the AMA. He was also the recipient of several awards including Michigan's Foremost Family Physician (1948); Wayne State University Alumni Award (1952); Denison University

Citation for Distinguished Citizenship (1956); and the Wayne State University School of Medicine Alumni Association's Distinguished Service Citation (1956).

Robert J. Fles, MD, a Muskegon internist, died March 26, 1996, at the age of 78. A 1954 graduate of the University of Louisville (Ky) Medical School, Doctor Fles was affiliated with Hackley and Mercy Hospitals, Muskegon.

James P. Gallagher, MD, Allen Park cardiovascular disease specialist, was installed May 11th as president of the Wayne County Medical Society. New president-elect of WCMS is Michael A. Sandler, MD, West Bloomfield diagnostic radiologist.

Elias D. Haddad, MD, a Detroit internist, died March 13, 1996, at the age of 85. A 1938 graduate of St. Joseph University Medical School, Beirut, Lebanon, Doctor Haddad was affiliated with Detroit's Deaconess Hospital.

Willard H. Howard, MD, a Kalamazoo general practitioner, died April 22, 1996, at the age of 88. A 1935 graduate of the College of Medical Evangelists, California, Doctor Howard was affiliated with Borgess and Bronson Hospitals in Kalamazoo.

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Robert L. Alexander, MD, 345 Highland Ct., Plainwell, MI 49080

Action, Date Taken: Amended Final Order dated 3-28-96 on remand from Ingham County Circuit Court Order dated 11-28-95, License Revoked, Fine - \$50,000.00, 08-03-90.

Reason: Drug Related

Name: Arthur P. Bober, MD, 25545 Tweed, Franklin, MI 48025

Action, Date Taken: License Summarily Suspended, 03-25-96

Reason: Substance Abuse

Name: John N. DiBella, MD, 702 S. Ballenger Hwy., Ste. 306, Flint, MI 48532

Action, Date Taken: License Suspended - minimum 1 day, Upon reinstatement, 2 years probation, Fine - \$2,000, 05-10-96

Reason: Negligence

Name: Timothy B. Elliot, DO, Baldwin Family Health Care, 4967 N. Michigan Avenue, Baldwin, MI 49304

Action, Date Taken: Summary Suspension Dissolved, 04-01-96

Reason: None Given

Name: Samir El-Yamani, MD, 329 93rd Street, Apt. 3C, Brooklyn, NY 11209

Action, Date Taken: Modification to Final Order Granting

Reinstatement dated 4-29-94; Upon successful completion of SPEX Exam, Reinstatement w/Limited License

Reason: None Given

Name: Eugene T. Komasa, DO, 8124 E. 10 Mile Rd., Center Line, MI 48015

Action, Date Taken: Limited License, Reprimand, Fine - \$1,000.00, 05-06-96

Reason: Drug Related

Name: James W. Ledrick, MD, 7505 Aspenwood, SE, Grand Rapids, MI 49546

Action, Date Taken: CORRECTION-EFFECTIVE DATE 10-15-95: License Suspended - 6 mo., Limited License - minimum 2 yrs., Probation - 2 yrs.

Reason: Negligence/Incompetence

Name: Samuel Mendoza, MD, 938 Aldine Bender Rd., Houston, TX 77032

Action, Date Taken: License Revoked, Fine - \$50,000, 05-09-96

Reason: Negligence/Incompetence, Unprofessional Conduct ■



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INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agents.

CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: **Excessive Hypotension:** Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beta-blocker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

Increased Angina and/or Myocardial Infarction: Rarely, patients, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angina or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawal: When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of nifedipine treatment will not prevent this occurrence and on occasion has been reported to increase it.

Congestive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning nifedipine. Patients with tight aortic stenosis may be at greater risk (for such an event), as the unloading effect of nifedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of ADALAT CC is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg, 12% at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought to be associated with vasodilation of dependent arterioles and small blood vessels and not due to left ventricular dysfunction or generalized fluid retention. With patients whose hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Information for Patients: ADALAT CC is an extended release tablet and should be swallowed whole and taken on an empty stomach. It should not be administered with food. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted. The relationship to nifedipine therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms; however, cholestasis with or without jaundice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it rarely resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum uric acid, glucose, cholesterol or potassium.

Nifedipine, like other calcium channel blockers, decreases platelet aggregation *in vitro*. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some nifedipine patients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated.

Positive direct Coombs' test with or without hemolytic anemia has been reported but a causal relationship between nifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although nifedipine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some.

Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been occasional literature reports suggesting that the combination of nifedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with cardiovascular disease.

Digitalis: Since there have been isolated reports of patients with elevated digoxin levels, and there is a possible interaction between digoxin and ADALAT CC, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

Coumarin Anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

Cimetidine: Both the peak plasma level of nifedipine and the AUC may increase in the presence of cimetidine. Ranitidine produces smaller non-significant increases. This effect of cimetidine may be mediated by its known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of nifedipine. If nifedipine therapy is initiated in a patient currently receiving cimetidine, cautious titration is advised.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy Category C. In rodents, rabbits and monkeys, nifedipine has been shown to have a variety of embryotoxic, placental toxic and fetotoxic effects, including stunted fetuses (rats, mice and rabbits), digital anomalies (rats and rabbits), rib deformities (mice), cleft palate (mice), small placentas and underdeveloped chorionic villi (monkeys), embryonic and fetal deaths (rats, mice and rabbits), prolonged pregnancy (rats; not evaluated in other species), and decreased neonatal survival (rats; not evaluated in other species). On a mg/kg or mg/m² basis, some of the doses associated with these various effects are higher than the maximum recommended human dose and some are lower, but all are within an order of magnitude of it.

The digital anomalies seen in nifedipine-exposed rabbit pups are strikingly similar to those seen in pups exposed to phenytoin, and these are in turn similar to the phalangeal deformities that are the most common malformation seen in human children with *in utero* exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADALAT CC in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive patients. Atenolol 50 mg once daily was used concomitantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

The most common adverse event reported with ADALAT[®] CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily and 29% on ADALAT CC 90 mg daily versus 10% on placebo.

Other common adverse events reported in the above placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Fatigue/asthenia (4%, versus 4% placebo incidence); Nausea (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Body as a Whole/Systemic: chest pain, leg pain **Central Nervous System:** paresthesia, vertigo **Dermatologic:** rash **Gastrointestinal:** constipation **Musculoskeletal:** leg cramps **Respiratory:** epistaxis, rhinitis **Urogenital:** impotence, urinary frequency

Other adverse events reported with an incidence of less than 1.0% were:

Body as a Whole/Systemic: cellulitis, chills, facial edema, neck pain, pelvic pain, pain **Cardiovascular:** atrial fibrillation, bradycardia, cardiac arrest, extrasystole, hypotension, palpitations, phlebitis, postural hypotension, tachycardia, cutaneous angiectases **Central Nervous System:** anxiety, confusion, decreased libido, depression, hyperlonia, insomnia, somnolence **Dermatologic:** pruritus, sweating **Gastrointestinal:** abdominal pain, diarrhea, dry mouth, dyspepsia, esophagitis, flatulence, gastrointestinal hemorrhage, vomiting **Hematologic:** lymphadenopathy **Metabolic:** gout, weight loss **Musculoskeletal:** arthralgia, arthritis, myalgia **Respiratory:** dyspnea, increased cough, rales, pharyngitis **Special Senses:** abnormal vision, amblyopia, conjunctivitis, diplopia, iriditis **Urogenital/Reproductive:** kidney calculus, nocturia, breast engorgement

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergic hepatitis, alopecia, anemia, arthritis with ANA (+), depression, erythromelalgia, exfoliative dermatitis, fever, gingival hyperplasia, gynecomastia, leukopenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.

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EDUCATIONAL OPPORTUNITIES

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June

25-29, Internal Medicine 1996 - Advances and Controversies. Location: Dublin, Ireland. **Sponsor:** Mayo Clinic and the Department of Medicine, Royal College of Surgeons in Ireland Medical School. **Contact:** Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905 (800) 323-2688.

July

14-16, 10th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: The Grand Hotel, Mackinac Island, MI. **Sponsors:** The University of Michigan Medical School, Department of Radiology. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 15 credit hours in Category I of the Physician's Recognition Award of the AMA to be announced.

18-21, Gastroenterology for the Gastrointestinal Consultant. Location: Shanty Creek Resort,

Bellaire, MI. **Sponsors:** The University of Michigan Medical School, Division of Gastroenterology, Department of Internal Medicine. **Contact:** Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, (313) 763-1400. **Approved for:** 12 credit hours in Category I of the Physicians Recognition Award of the AMA.

29-August 2, Dynamic Psychotherapy in the New Era: Possibilities and Problems. Location: The Given Biomedical Institute, Aspen, Colorado. **Sponsor:** American Psychiatric Association. **Contact:** Maria Gorrick, (phone) 202-682-6145; (fax) 202-682-6102; (e-mail) MGORRICK@psych.org.

August

8-10, Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis. Location: Leighton Auditorium, Siebens Building, Mayo Clinic, Rochester, MN. **Contact:** Postgraduate Courses, Section of International Medical Education, Mayo Foundation, Rochester, MN 55905. Phone: 800-323-2688. Fax: 507-284-0532.

18-20, Success with Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure. Location: Vail Cascade Hotel, Vail, Colorado. **Contact:** Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St., S. W., Rochester, MN 55905. Phone: 1-800-323-2688. Fax: (507) 284-0532.

ONGOING

Case Studies in Environmental Medicine. Location: Your office/home (self-instructional monographs). **Sponsor:** The Agency for Toxic Substances and Disease Registry, Division of Health Education. **Contact:** Michele Borgialli, Michigan Department of Public Health, Division of Health Risk Assessment, P.O. Box 30195, Lansing, MI 48909, (517) 335-9647. **Approved for:** Up to 33 hours of free Category I Credits; 1 per case study. ■



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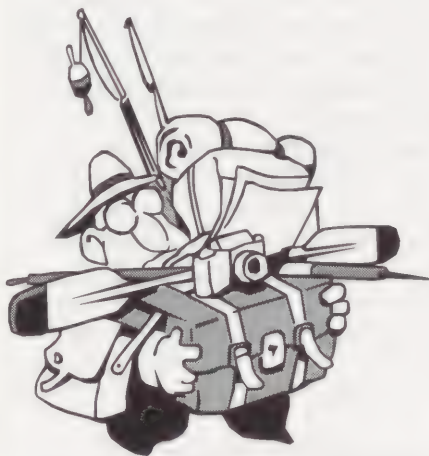
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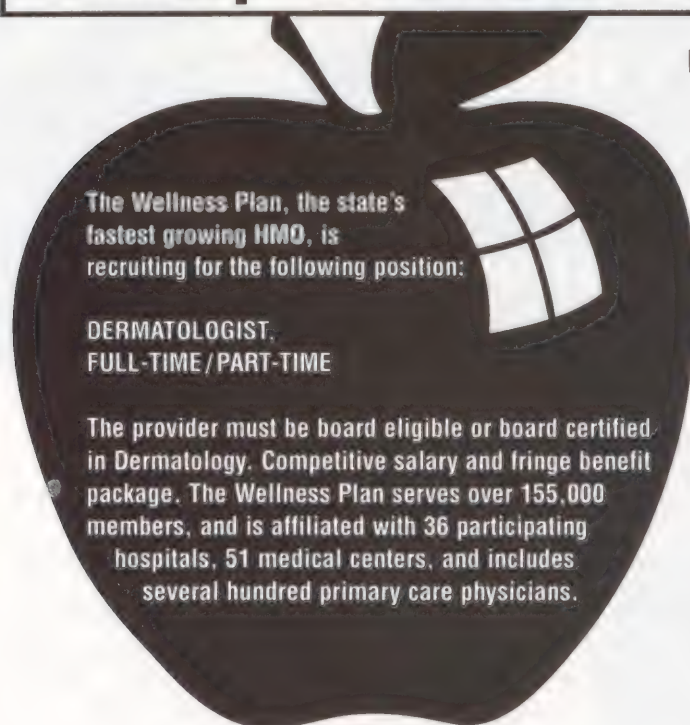
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(continued from page 56)

On the immediate level are existing mechanisms of peer review. And that's where Kevorkian founders. No doctor should be without the oversight of his/her peers. Recently Kevorkian has assembled a veneer of peer oversight through the Physicians of Mercy. But to me that's not true peer review, that's just stacking the deck with agenda-driven individuals... little Kevorkians without the chutzpah.

But I read the tea leaves, and trusting it to the doctor/patient/relationship is unlikely to happen. Rather it appears destined to be controlled by panels of judges.

However it plays out, and whatever may be the individual physician's personal views on the ethics of assisted suicide, the profession must above all else guard against being a pawn in this debate, of being used to wash society's dirty linen.

Doctor McCabe is MSMS president.

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Assisted Suicide Revisited

Profession must not become pawn in the debate.

By W. Peter McCabe, MD

It's more than a little ironic that, at a time when you can't turn on TV without seeing Kevorkian or Feiger, our recent House of Delegates proceedings saw nary a single resolution on assisted suicide. And it was the same last year. Are MSMS delegates hopelessly out of touch with the compelling issues of the day? Or have we made our peace with assisted suicide, or to use the vernacular of the death crowd, "come to closure" regarding it?

The latter, thank you. From 1991 through 1993 MSMS put a prodigious amount of thought and effort into the subject, and finally adopted the position that there should not be any legislation for or against assisted suicide. I personally thought at the time this was a non-position, a way of avoiding the issue; but as your officers have grappled with this tortured subject I have acquired a belated appreciation of its wisdom.

Society in general, and our profession in particular, is divided on assisted suicide. If we could be assured that it would stay at just that, and be exercised with great discretion after all other remedies had been exhausted, for a sharply limited range of situations, then some might feel that perhaps a place could be found for this activity.

The problem is that no such assurances can be given. In Germany in the early 1930s, what started out as a seemingly altruistic program to ease the suffering of the hopelessly sick and handicapped in fact laid the groundwork for the horrors of the Holocaust. Starting the descent down the slippery slope may truly be opening Pandora's box.

Whether or not the word "physician" is attached to the term "assisted suicide," you can bet they have us in mind when attention turns to the assistance. In suicide we provide the "dignity"...no mess, no splatter, just nice high-tech efficiency that offers the least intrusion on everyone's sensitivities. There can't be any other reason. After all, roughly 30,000 people a year commit suicide without our assistance.

But this ending of a life is dicey business about which we are all deeply ambivalent. The hangman wears a hood, the firing squad always has one or two whose rifles lack bullets. Having us assist makes it all very hygienic, sanitizing it, adding a veneer of respectability to a process about which society isn't really sure.

But whatever the arguments for or against, there is a practical matter for us to contend with, and that's the mission society has as-

signed to the physician. For a variety of reasons the role of the doctor should be clear and unambivalent...to heal and to relieve suffering. Muddying that identity by adding another role that frequently would be in conflict only subverts that primary mission.

That is not to say that the envelope can't be pushed. But formalizing assisted suicide with the inevitable guidelines will entail years of endless wrangling over who, when, and what. There are those who say that this has gone on quietly for years, and guidelines would merely bring it out of the closet. A federal appeals judge, Guido Calabrese, may have hit the nail on the head, however, when he observed, "It may well be that a society may prefer subterfuge and covert practice to trying to draw lines that are extraordinarily difficult to draw."

Leaving these decisions to the doctor/patient/family relationship raises the inevitable accusations about "the old boy network." However, there are mechanisms in place to guard against abuse. For one thing there is existing criminal and civil law, although the legal system has been functioning recently like Keystone cops.

(continued on page 55)

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